



- | | |
|--|--|
| <input type="checkbox"/> James Miller, DO | <input type="checkbox"/> Robin Spencer, NP |
| <input type="checkbox"/> John Bustle, MD | <input type="checkbox"/> Glenn Gardner, PA |
| <input type="checkbox"/> William Haynie, MD | <input type="checkbox"/> Laura Thiem, NP |
| <input type="checkbox"/> James Patterson, DO | <input type="checkbox"/> Misty Tourtillott, NP |

PO Box 370 | Butler, Missouri 64730
 Phone: 660-200-7133 | Fax: 660-200-2396

AUTHORIZATION TO ACCESS/DISCLOSE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize: _____ Phone number: _____
 to release healthcare information of the patient named above to:

Family Care Clinics
 PO Box 370
 Butler, MO 64730

For the purpose of continued treatment.

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- | | |
|---|-------------------------------------|
| <input type="radio"/> Radiology Reports | <input type="radio"/> EKG's |
| <input type="radio"/> Progress Notes | <input type="radio"/> Laboratory |
| <input type="radio"/> Pathology Reports | <input type="radio"/> Entire Record |
| <input type="radio"/> Other _____ | Dates of Treatment _____ |

- I understand that the information in my health record may include information relating to STDs, AIDS/HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse (including alcohol and drug screening tests).
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the hospital's Privacy Officer.

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to Patient if Representative: _____

Witness: _____ Date: _____