LIBERTY HOSPITAL

LIBERTYHOSPITAL.ORG

MRN#_____

Account #_____

Patient Identification

Patient Name: _____ Birth Date: _____/_____/_____

Address: _____ City: _____State: _____ Zip Code: _____

Phone Number: _____ Email Address:_____

I request my protected health information (PHI) to be released from:

□ Liberty Hospital □ The Liberty Clinic □ The Surgeons Clinic

□ The Kearney Clinic □ Liberty Sports Medicine

□ The Excelsior Springs Clinic □ Liberty Cardiovascular Specialist

Purpose of Request

□ Legal □ Personal □ Insurance □ Continuation of Care

How information is to be received

□ US Mail □ Pick Up □ CD

□ Fax (for healthcare providers only) □ Email- (Must complete the DMRS Record Delivery Request form)

I request my protected health information (PHI) to be released to:

Name:_____Phone:_____Email:_____

Address:_____Fax (Healthcare provider only):_____

City/State:_____ Zip Code:_____

Specific date(s) to be released:

From _____ to _____

I authorize the following PHI to be released from my medical records:

□ ***Abstract** □ Emergency Room Record □ Radiology Reports □ Laboratory Reports □ Pathology Reports

□ Cardiology Reports □ Radiology Imaging □ Other (specify): _____

*Abstract for hospital consists of face sheet, history and physical, discharge summary/discharge instructions, consultations, operative reports, pathology reports, emergency room record, lab reports, radiology reports, EKG reports, and cardiology reports (if available). *Abstract for Clinics consists of office notes, labs radiology, EKG, or immunizations.

Treatment of Drug/Alcohol Abuse, Mental Health, Communicable Diseases, and HIV/AIDS Records Release

PHI that may be released from the medical record may include mental health, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse unless indicated below by checking the box.

□ **I do not authorize the release of mental health, communicable diseases, HIV/AIDS, and treatment of alcohol/drug abuse.**

I understand that requests for copies of medical records and/or non-document material may be subject to copying fees. This authorization may be revoked at any time except to the extent already acted upon. Revocation must be made in writing and presented to Liberty Hospital, Health Information Management, PO Box 1002, Liberty, MO 64068. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand I may refuse to sign this authorization. Once release of this information is made to the above named person or persons, my information may be subject to re-disclosure by that person or persons and the information may not be protected by federal confidentiality rules. Disclosure of this information is in accordance with 42 CFR Part 2, and 45 CFR Parts 160 and 164. I understand that by signing this document I release and discharge Liberty Hospital from any liability and will hold Liberty Hospital harmless for any release made pursuant to this authorization.

This authorization will expire one year from the date signed unless I specify specific date, event or condition. _____

I have read the above and authorize the disclosure of the protected health information as stated.

Patient/Authorized Representative Signature: _____ Date: _____ Time: _____

Printed Name of Authorized Representative: _____ Relationship to Patient: _____

If signed by patient's authorized representative, supporting legal documentation MUST accompany this form.

Employee Completing this Request: _____ Account # _____ Date: _____ Time: _____