AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO UNIVERSITY OF MISSOURI HOSPITALS & CLINICS - COLUMBIA

Authorization for Release of Patient's Records

4/19/16 edition

We are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment or health care operations, as set forth more fully in our Notice of Privacy Practices. In our Notice of Privacy Practices, we provide information about how MU Health Care can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this Authorization.

Patient's Name: _____ Date of Birth: _____SSN: _____

A copy of this Authorization will be kept in the Autism Center office and will be available to you on your request.

I, _____, have read the information below and authorize the below named institution to disclose the identified information between one another. I understand that, by signing this document, I release and discharge the providing institution from any liability and will hold such institution harmless for any release made pursuant to this Authorization.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Relationship of legal representative (if not patient's signature)

_____ _____

Signature of Witness Date

I hereby authorize and request the below named institution/physician and all physicians, surgeons or employees who attended or treated me while I was a patient in said institution, to furnish to the UNIVERSITY OF MISSOURI HEALTH CARE all records as indicated below, concerning my case history and the treatment, examinations, or hospitalizations received by me while in said institution and I also authorize said institution/physician to permit the UNIVERSITY OF MISSOURI HEALTH CARE transcript of all my said records, or such portion thereof as may be requested.

I AUTHORIZE THE RELEASE OF INFORMATION TO UNIVERSITY OF MISSOURI HEALTH CARE

_____

Name of Institution (Hospital, Office, Physician)

_____

Street Address

_____

City State Zip

The Following information will be released:

☐ ASD Diagnostic Report Date of ASD Diagnosis _____

☐ IQ Assessment Date of IQ Assessment _____

☐ Other (Specify)

Purpose for which this information will be used: STRIVE program consideration

Please Send Information To: STRIVE Program
Thompson Center for Autism and Neurodevelopment
Attn: Jaclyn Benigno
205 Portland St.
Columbia, MO 65211
FAX: (573) 884-1982

Please turn form over and continue reading ≡

I hereby release the institution from which records are released, and its employees, from any and all liability, claims or causes of action for providing the medical information requested regarding my treatment, hospitalization, or outpatient care including psychological, psychiatric, substance abuse, alcoholism, sickle cell anemia, acquired immunodeficiency or test for infection with human immunodeficiency virus.

IN REGARD TO RECORDS RELEASED **FROM** UNIVERSITY OF MISSOURI HEALTH CARE:
You may request to inspect or copy the information that the University Hospital intends to disclose. University of Missouri Health Care may NOT require that you sign this Authorization to receive treatment. You may refuse to sign this Authorization. If you refuse to sign this authorization, the requested information will not be released. Once release of this information is made to the above named person or persons, your information may be subject to re-disclosure by that person or persons. **Information received by the University Hospital from outside sources will NOT be re-disclosed to any other institution, except where required by law.**

You may revoke this Authorization in writing at any time, except to the extent that we have already released information in reliance on this Authorization. Notice of revocation of this consent should be delivered to the University Hospital address listed above. Unless you revoke this Authorization in writing, this Authorization will expire in 1 year from the date it was signed or upon expiration of the event for this the authorization was requested.

If you are requesting information for yourself or for a third party, University of Missouri Health Care may assess appropriate and reasonable fees for the copying of such information. Such fees will comply with all state and federal laws.

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that Federal Law protects those records. The authorization for Release of Information form does not authorize re-disclosure of medical records beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse prohibits information disclosed from records protected by this law from being otherwise disclosed, even to the patient, without a specific written consent of the person to whom it pertains or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical records or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute the patient.