General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please print or type:

Patient Name: _____

Address: _____

Phone: _____-_____-_____SSN: _____-_____-_____Date of Birth:_____/_____/_____

I authorize: _____

Phone: _____ Fax: _____

to disclose/release the following information (check all applicable and see **Note below):

- ☐ All records
- ☐ X-ray/radiology records
- ☐ Abstract/Summary
- ☐ Laboratory/pathology records
- ☐ Billing records
- ☐ Pharmacy/prescription records
- ☐ Current OB records and relating Labs, U/S reports, etc - Dates _____
- ☐ Operative Reports for dates of service: _____
- ☐ Other (describe specifically) _____

****We require notification if there is a fee for obtaining these medical records in advance of disclosing them! Please notify us *in advance* at the phone # below. Thank you.**

*****Note:* If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.***

I authorize my medical records to be released to:

Bay Point Maternity & Women's Health
Martin Schwartz, MD
1029 Nichols Road, Ste E
Osage Beach, Mo 65065
Ph. 573-302-4884 F: 573-302-4434

OR

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

The information may be used/disclosed for each of the following purposes:

- ☐ Personal Use (only the patient can check this box)
- ☐ For payment/insurance
- ☐ For my health care/ Continuation of Care
- ☐ For employment purposes
- ☐ Other: _____

This authorization shall expire no later than: ___/___/___(90 days) or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature for Missouri medical records.

I understand that after the custodian of records discloses my health information; it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to sign for patient,
(i.e parent, guardian, power of attorney for healthcare, executor)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written notice to the Privacy Liaison at the above address. You are entitled to a copy of this consent. This form does not constitute legal advice and covers only federal, not state, laws.