Western Missouri MEDICAL CENTER

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Name of Patient

Previous Names, If applicable

Date of Birth

Daytime Telephone Number

SEND INFORMATION TO: (please be specific)
Patient Name/Provider Name/Organization/Attorney: _____

Address: _____

Phone#: _____ Fax#: _____

INFORMATION TO BE RELEASED FROM: (please be specific)
Provider Name/Organization: WESTERN MISSOURI MEDICAL CENTER
Address: 403 BURKARTH ROAD, WARRENSBURG, MO. 64093
Phone#: 660-747-2500 Fax#: 660-747-9483

PURPOSE OF DISCLOSURE: [] Personal Use [] To Physician [] Legal [] Other_____
(Specify)

INFORMATION TO BE DISCLOSED: _____

PLEASE BE SPECIFIC "ANY AND ALL" WILL NOT BE ACCEPTED.

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. I understand that WMMC shall not condition treatment or payment on the completion of the authorization. I understand that this authorization may be revoked in writing and delivered to the Health Information Mgmt. Dept. of WMMC at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that once the Information is disclosed per my instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

Date | Signature of Patient or representative | Relationship to patient

Date | Signature of WMMC Witness

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment for.

- HIV/AIDS Virus
- ALCOHOL AND DRUG
- GENETIC TESTING
- MENTAL HEALTH

Date | Signature of Patient or representative | Relationship to patient

THIS AUTHORIZATION EXPIRES 90 DAYS FROM DATE OF SIGNATURE

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