JCMG | JEFFERSON CITY MEDICAL GROUP

Medical Records – Release of Information
1241 W. Stadium Blvd. Jefferson City, MO 65109
Email – medicalrecords@jcmg.org
Phone: (573) 556-7787 - Fax: (573) 761-3262

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As outlined in our Notice of Privacy Practices, Jefferson City Medical Group (JCMG) is required by law to obtain your authorization for most uses and disclosures of your health information that are related to treatment, payment, or health care operations. Our Notice of Privacy Practices provides details on how JCMG may use or disclose your health information. You have the right to review this notice before signing any authorization.

Patient Name: _____ Date of Birth: _______________

Address: _____

City: _____ State: _____ Zip Code: _____

RELEASE INFORMATION AT THE REQUEST OF UNDERSIGNED INDIVIDUAL

I, _____ (Name of Patient or Patient Representative) hereby authorize JCMG to:

☐ Obtain From | ☐ Release To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email (If Applicable): _____

Phone Number: _____ Fax Number: _____

INFORMATION TO BE RELEASED TO OR FROM JEFFERSON CITY MEDICAL GROUP (JCMG)

☐ Entire Record

☐ Reproductive Health

☐ Office Visit (Dates) _____

☐ Other (Please Specify) _____

☐ Radiology Images (Dates) _____

☐ Radiology Report (Dates) _____

☐ Lab (Dates) _____

INFORMATION TO BE RELEASED TO OR FROM JCMG CENTER FOR WELL-BEING PATIENTS ONLY

☐ Entire Record

☐ Initial Assessment

☐ Progress Notes

☐ Psychological Testing Interpretation

☐ Substance Use / Treatment

☐ Treatment Recommendations

☐ Treatment Plan

☐ Discharge Summary

☐ Educational Plans / Evaluations

☐ Other (Please Specify) _____

Revised 04/2026

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RELEASE OF THIS INFORMATION IS BEING MADE FOR THE FOLLOWING PURPOSE:

☐ Continuation of Care ☐ Provider Request ☐ Personal Use ☐ Other _____

MEDICAL RECORDS DELIVERY FORMAT – CHOOSE ONLY ONE (1)

☐ Electronic Delivery (Secure File via Email) ☐ Paper Copy – Fax / Mail / Pick Up ☐ CD

Email Address if Applicable: _____

DISCLOSURE

JCMG will not release any information, including history of illness or diagnostic and therapeutic information, regarding psychotherapy notes and/or treatment for alcohol abuse, drug abuse, or Acquired Immune Deficiency Syndrome (AIDS) without specific written consent from the patient and/or the legal guardian. By initialing below, I am authorizing release of this information. **SIGNER MUST INITIAL THIS CLAUSE: _____**

EXPIRATION

This authorization will expire one year from the date of signature. If you would like this date to be less than one year, please indicate the date below. If the patient is a minor, release is valid only until the patient's 18th birthday (Not applicable for patients with a Power of Attorney or Guardianship). **EXPIRATION DATE: _____**

SIGNATURE

When protected health information is used or disclosed according to this authorization, it may be subject to further disclosure by the recipient and might no longer be protected by the federal HIPAA Privacy Rule. This authorization can be revoked in writing at any time, except when the covered entity has already used or disclosed information based on this authorization, or when an insurer uses the authorization if it was required for insurance coverage. The covered entity will not make treatment, payment, enrollment, or eligibility for benefits dependent on signing a release, except when necessary for research-related treatment, health care provided solely to generate protected health information for third-party disclosure, or when a health plan conditions enrollment or benefit eligibility on receiving an authorization.

I hereby acknowledge my authorization to release the above referenced patient health information as directed by my instructions.

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name of Patient or Legal Guardian: _____ Patient Relation: _____

OFFICE USE ONLY

Verified by Signature: _____ Verified by Print Name: _____

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature

Verified documentation supporting personal representative's authority to act on behalf of the patient:

☐ Yes ☐ No ☐ Not Applicable

Document Type Verified: _____