Patient Authorization to Release Protected Health Information

Jefferson City Medical Group
1241 West Stadium Blvd.
Jefferson City, MO 65109
Phone: (573) 556-7787
Fax: (573) 761-3262
Email: medicalrecords@jcmg.org

1) Patient Information

Patient Name: _____ Date of Birth: _______________
Street: _____ City: _____ State: _____ Zip: _____

2) Release Information at the Request of the Undersigned Individual

To:
Name or Org.: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Patient Email: _____

From:
Name or Org.: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

3) Description of Information to be Disclosed; i.e. all records, labs only, office visits, etc. Please specify dates.

4) Information to be Exchanged or Released for JCMG Professional Therapy Center Patients Only

☐ Initial Assessment ☐ Psychological Testing Interpretation ☐ Treatment Plan
☐ Progress Notes ☐ Substance Use / Treatment ☐ Discharge Summary
☐ Entire Record ☐ Treatment Recommendations ☐ Educational Plans / Evaluations
☐ Other (Please Specify) _____

5) Purpose for the Release of Information

☐ Continuation of Care ☐ Patient Request ☐ Provider Request
☐ Other _____

6) 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 signing below, I am authorizing release of this information.

Signature to approve release of requested information: _____

7) Expiration

This authorization will expire one year from the date of signature. If you would like for 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 Durable Power of Attorney or Guardianship). Expiration Date: _____

8) Signature

When my protected health information is used or disclosed pursuant to this authorization, I understand it may be subject to re-disclosure by the recipient and may no longer by protected by the federal HIPAA Privacy Rule. I understand I may revoke this authorization in writing at any time, except to the extent that the covered entity has previously used or disclosed information in reliance of this authorization, and except to the extent the authorization can be used by an insurer if it was obtained as a condition of obtaining insurance coverage. The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits upon the undersigned individual signing a release, except when it is required for research-related treatment, required for health care that is solely for the purpose of creating protected health information for disclosure to a third party, or where a health plan conditions enrollment in the health plan or eligibility for benefits on provision of 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: _____

9) Staff Use Only

Witness Signature: _____ Witness Initials: _____ Photo ID Verified ☐