COMC
MEDICAL · BEHAVIORAL · DENTAL
Your Health.....Our Mission.

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Central Ozarks Medical Centers

Patient Name: _____ DOB: _____ SSN: _____

_____

Address City, State Zip Phone Number

I, _____ hereby authorize COMC to ☐ obtain / ☐ release my medical or dental records from:

Name of Patient

_____

Name of Facility & Contact Person Phone Number

_____

Address of Institute Releasing Information Fax Number

Please mail or fax records to:

COMC
304 W Washington Ave
P.O. Box 777
Richland, MO 65556
Fax: 573.765.3824

PERSON TO BE CONTACTED WHEN RECORDS ARE RECEIVED:

_____

Contact Name: Contact Phone #:

_____

Pending appointment date and time (if applicable):

The following information is requested for release:

☐ COMC progress notes

☐ Dental records

☐ Behavioral Health Records

☐ Lab Results

☐ Statements of charges and payments

☐ X-rays and other imaging

Permission to obtain the following information:

☐ Progress notes

☐ Dental records

☐ Behavioral Health Records

☐ Lab Results

☐ X-rays and other imaging

Dates of treatment to be released: From: _____ **to** _____ **.**

Please see reverse

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Release of this information is being made for the following purpose: _____
(Describe the reason for the request)

PSYCHIATRIC, DRUG AND/OR ALCOHOL ABUSE, HIV/AIDS RECORDS RELEASE:

I understand if my medical or billing record contains information in reference to *psychiatric testing and/or treatment* I agree to its release. Check one: ☐ Yes ☐ No

I understand if my medical or billing record contains information in reference *to drug and/or alcohol abuse*, *sexually transmitted disease*, *Hepatitis B or C testing*, and/or other *sensitive information*, I agree to its release.
Check one: ☐ Yes ☐ No

I understand if my medical or billing record contains information in reference to *HIV/AIDS testing and/or treatment* I agree to its release. Check one: ☐ Yes ☐ No

You may request to inspect or copy the information that the institute intends to disclose. COMC 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 disclosed to the above named person or persons, your information may be subject to re-disclosure by that person or persons. You may revoke this authorization at any time, except to the extent that the sending institute has already released information in reliance on this authorization. Typically, this is accomplished on our Revocation Form, but alternative means of notice are acceptable. Unless you revoke this authorization, this authorization will expire on the following date or condition_____. If you do not fill out a specific date or condition upon which this authorization will expire, it will automatically expire six months from the date of your signature.

I,_____ , have read the above information and authorize COMC to request the identified information from the persons and for the purpose described herein. I understand that, by signing this document, I release and discharge the above institution from any liability and will hold that institution harmless for any release made pursuant to this authorization. A copy of this authorization will be available to you after you sign it.

_____ _____
Signature of Patient or Legal Representative* Date

* If signed by the Legal Representative, he or she should describe the nature of his or her authority to sign for the patient and attach a copy of the documentation.