



COMC

CENTRAL OZARKS MEDICAL CENTER

MEDICAL · BEHAVIORAL · DENTAL · VISION

Your Health.....Our Mission.

Authorization to Release or Request Medical Records

Patient Name: _____ Date of Birth: _____

Social Security Number (Last 4 digits): _____ Phone: _____

Address: _____

I hereby voluntarily authorize Central Ozarks Medical Center to release information to:

Name

Address

City, State, Zip Code

Phone

Fax

* Please send records via fax

I hereby voluntarily authorize Central Ozarks Medical Center to obtain information from:

Facility Name

Facility Address

City, State, Zip Code

Facility Phone

Facility Fax

*Please do not send via CD/Disc

Purpose of Release:

- Treatment or Consultation
 - At Request of Patient or Individual
 - Insurance
 - Attorney/Legal
 - Probation/Parole
 - Other: (please specify)
- _____



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Information to Be Disclosed (check all that apply):

- All Records Medical Records Dental Records Behavioral Health Records Billing
- Laboratory X-ray/Imaging Immunizations Medications
- Substance Use Disorder (SUD) Treatment Records (42 C.F.R. Part 2)
- Specific Records: _____
- Date Range of Services: _____

Substance Use Disorder Treatment Records (42 C.F.R. Part 2)

Federal law (42 C.F.R. Part 2) protects records relating to substance use disorder diagnosis, treatment, or referral for treatment. If this authorization includes SUD treatment records, I specifically authorize Central Ozarks Community Health Center to disclose such records as described above.

I understand that:

- My SUD treatment records are protected by federal law.
- This authorization permits disclosure as described above.
- Once disclosed pursuant to this authorization, the information may be used and disclosed by the recipient in accordance with the HIPAA Privacy Rule and other applicable laws; however, federal law continues to protect substance use disorder treatment records and limits certain uses and disclosures as provided under 42 C.F.R. Part 2.
- I may revoke this authorization at any time, except to the extent action has already been taken in reliance on it.

Expiration

This authorization expires one year from signature date unless otherwise noted.

Patient Rights and Acknowledgement:

I understand that:

- I do not have to sign this authorization.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this form.
- I may inspect or copy the information to be disclosed.
- I am entitled to a copy of this signed authorization.

Signature of Patient/Legal Guardian

Date

Printed Name of Representative (if applicable):

Relationship to Patient: