*** NO DISKS PLEASE ***

BooneHealth
BOONE MEDICAL GROUP

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Authorization for Release of Information

I hereby authorize/request (list facility)

_____

to release medical information of:

Patient Name: _____ _____ _____
(Last) (First) (M.I.)

Maiden/Former Name(s) (where applicable)**:** _____

Date of Birth (MM/DD/YYYY)**:** _____ **SSN:** _____

_____ _____
Patient's Street Address, City, State and Zip Code **Phone Number**

I request the following information be released:

- ☐ All Medical Records
- ☐ Primary Care Records (specify provider(s) or practice): _____
- ☐ Specialist Records (specify provider(s), practice or specialty): _____
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Itemized Billing Statement
- ☐ Other (specify): _____

Test results and/or diagnosis and treatment information, if any, concerning substance use/abuse, psychiatric/behavioral health information, OBGYN records (include pregnancy test results), and AIDS/HIV and other communicable diseases contained within my medical records indicated above **will be released** through this authorization unless indicated below.

Please initial information you **DO NOT** want released:
_____ Substance Use/Abuse _____ Psychiatric/Behavioral Health _____ OBGYN Records
_____ AIDS/HIV and other communicable diseases _____ Other (specify): _____

This request is limited to the following date(s) of treatment:

- ☐ Date (MM/DD/YYYY): _____
- ☐ Dates From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____
- ☐ All Dates of Treatment

This medical information is for the purpose of:

- ☐ Self
- ☐ Further medical care
- ☐ Changing physicians
- ☐ Attorney review
- ☐ Disability
- ☐ Workers Comp
- ☐ Insurance Eligibility/Benefits
- ☐ Litigation
- ☐ Other (specify): _____

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential."

Revision Date: 04/09/2021

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Release or mail to:

_____

Name of Individual/Physician/Facility/Agency

_____

Street Address, City, State and Zip Code

_____

Phone Number

OR

□ **Release to Patient at the Address listed on this form**

By signing below, I acknowledge and agree that:

- I understand that neither Boone Health nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.
- I understand I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This authorization will expire one (1) year from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax or bring the letter to the address or fax number listed below:

  Boone Medical Group – Surgery
  1601 E. Broadway, Suite 240
  Columbia, MO 65201 FAX 573-815-3832

- If I am signing on behalf of a patient for whom I am the legal guardian or personal representative, I must attach a certified copy of my appointment as legal guardian or personal representative.

_____ _____

Signature of Patient/Legal Guardian/Personal Representative **Date**

_____

Print Name

_____

Relationship to Patient (If someone else signs on behalf of the patient, state your relationship to patient)

Practice/Provider Use Only:

Date Request Granted: _____

Other Disposition (Date/Action): _____

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