NORTHEAST MISSOURI HEALTH COUNCIL
"Partners for a Lifetime of health"

TO NMHC

For Office Use Only
Date Request Sent _____/_____/_____ Initials _____ Date Records Received _____/_____/_____ Initials _____
*(File form only **after** records are received)*

AUTHORIZATION TO RELEASE PROTECTED HEALTH FORM

PATIENT NAME: _____

DOB: _____/_____/_____ PHONE: _____-_____-_____ SS#: _____/_____/_____

I AUTHORIZE PHI FROM:

PROVIDER_____

CITY/STATE/ZIP_____

FAX# ( ) _____-_____ PHONE# ( ) _____-_____

To be DISCLOSED TO:

****Preferred method to send records: medrecords@nmhcinc.org**

☐ **NORTHEAST FAMILY HEALTH – KIRKSVILLE**
PHONE: 660-627-4493
FAX: 660-627-4288
medrecords@nmhcinc.org

☐ **NORTHEAST FAMILY HEALTH - EDINA**
PHONE: 660-397-3517
FAX: 660-397-2307
medrecords@nmhcinc.org

☐ **NORTHEAST FAMILY HEALTH - MILAN**
PHONE: 660-265-1042
FAX: 660-265-1043
medrecords@nmhcinc.org

☐ **OB/GYN SPECIALTY GROUP**
PHONE: 660-665-3555
FAX: 660-665-3547
medrecords@nmhcinc.org

☐ **NORTHEAST PEDIATRICS**
PHONE: 660-627-2229
FAX: 660-627-2233
medrecords@nmhcinc.org

☐ **MACON FAMILY HEALTH AND MACON DENTAL**
PHONE: 660-395-5045
FAX: 660-395-5048
medrecords@nmhcinc.org

☐ **KAHOKA DENTAL**
PHONE: 660-727-1500
FAX: 660-727-1502
medrecords@nmhcinc.org

☐ **NORTHEAST DENTAL**
PHONE: 660-665-2741
FAX: 660-665-3109
medrecords@nmhcinc.org

☐ **MEMPHIS COMMUNITY HEALTH CENTER**
PHONE: 660-465-7522
FAX: 660-465-7526
medrecords@nmhcinc.org

TREATMENT DATE(S) OF SERVICE:
☐ Last 12 months ☐ Last 24 months ☐ Specific Date Range _____/_____/_____ to _____/_____/_____

INFORMATION TO BE SENT:
☐ Lab/Pathology ☐ X-ray/CT/MRI ☐ Procedure Reports ☐Immunization Record
☐ Consults ☐ Progress Notes ☐ ER/Hospital Reports ☐Medication List
☐ Billing Records

PURPOSE OF DISCLOSURE:
☐ Continuity of Care ☐ Change Providers ☐ Legal ☐ Moving ☐ Other_____

I understand by signing this authorization, I am allowing release of any medical information requested to the agency or person specified above. By signing this authorization, I am allowing release of any drug and/or alcohol information, psychiatric, HIV testing and/or results or AIDS information contained within the records to the above named. ***I understand*** this authorization will expire when the records requested on this authorization have been released, or in 365 days, whichever occurs first. ***I understand*** I may revoke this authorization at any time by notifying The Northeast Missouri Health Council, Inc. in writing. ***I understand*** revocation will be effective on the date my notification is received and dated by Northeast Missouri Health Council, except to the extent that release of information action has already been taken. ***I understand*** information used or disclosed because of this authorization may be subject to additional disclosure by the recipient and may no longer be protected by Federal privacy regulations. ***I understand*** by signing or not signing this authorization, my healthcare and payment for my healthcare will not be affected. ***I understand*** I may request to see or copy the information described on this authorization and that I may request a copy of this authorization after I sign it.

AUTHORIZATION SIGNATURE

_____

Signature of Patient/Parent/Legal Guardian **Date**

_____

Witness Signature **Date**

Updated FEB 2023

Medical Record Requests will be processed within 30 days