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

TO dentalrecords@nmhcinc.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

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

Please send my records (PHI) FROM:

Dentist/Hygienist/Office/Hospital_____

Address/City/State/Zip_____

Fax/Email/Phone_____

Records (PHI) to be disclosed TO:

☐Northeast Dental	☐Macon Dental	☐Kahoka Dental
dentalrecords@nmhcinc.org	dentalrecords@nmhcinc.org	dentalrecords@nmhcinc.org
P: 660-665-2741	P: 660-395-5045	P: 660-727-1500
F: 660-665-3109	F: 660-395-5048	F: 660-727-1502

TREATMENT DATE(S) OF SERVICE:

☐ Last 12 months ☐ Last 24 months Specific Date Range _____/_____/_____ to _____/_____/_____

INFORMATION TO BE SENT:

☐ X-Rays ☐ Progress Notes ☐ Consults/Referrals ☐ER/Hospital Reports
☐Health History ☐ 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/Legal Guardian Date

_____

Witness Signature Date

FEB '25 *PHI requests will be processed within 30 days*

Date request sent ____/____/___ ***Initials*** ____ ***Date Records Received*** ____/____/____ ***Initials*** ____