



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DOB: ____/____/____ PHONE: ____-____-____ SS# ____/____/____

Please send my records (PHI) FROM:

Dr/NP/Clinic/Hospital _____

Address/City/State/Zip _____

Fax/Email/Phone _____

Records (PHI) to be disclosed TO:

Northeast Family Health-Kirksville
medrecords@nmhcinc.org

P: 660-627-4493

F: 660-627-4288

Northeast Family Health-Edina
medrecords@nmhcinc.org

P: 660-397-3517

F: 660-397-2307

Northeast Family Health-Milan
medrecords@nmhcinc.org

P: 660-265-1042

F: 660-265-1043

OBGYN Specialty Group
medrecords@nmhcinc.org

P: 660-665-3555

F: 660-665-3547

Northeast Pediatrics
medrecords@nmhcinc.org

P: 660-627-2229

F: 660-627-2233

Macon Family Health
medrecords@nmhcinc.org

P: 660-395-5045

F: 660-395-5048

Memphis Community Health Center
medrecords@nmhcinc.org

P: 660-465-7522

F: 660-465-7526

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/Legal Guardian

Date

Witness Signature

Date

FEB '25

Date request sent ____/____/____

Initials ____

Date Records Received ____/____/____

Initials ____

PHI requests will be processed within 30 days