AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

RELEASE INFORMATION FROM *(Specify Facility/Address)*	**DISCLOSE INFORMATION TO** *(Specify Facility/Individual/Address/Relationship)*
Osage Beach Center for Behavioral Health	
840 Passover Road	
Osage Beach, MO 65065	

PURPOSE OF DISCLOSURE	▫ Continued Care – healthcare facility, provider (abstract* will be provided, unless otherwise specified) ▫ Personal: I understand that I may be charged for copies of this information in accordance with Missouri law**. (Admin fee $28.57 plus $.66 per page or $125.50 whichever is less.)** ▫ Other: _____
INFORMATION TO BE DISCLOSED	Specify Service Dates:
	▫ Hospital Abstract (includes, as applicable, Discharge Summary, Discharge Medication List, History & Physical, Psychiatric Evaluation, Daily Psychiatric Progress Notes, Treatment Plan. ▫ Other: _____
IDENTIFYING INFORMATION AT THE TIME OF SERVICE	
Patient's Full Name	
Address	
City/State/Zip	
Last 4 digits of Patient's SS Number:	
Date of Birth	
Phone Number	

Requests for Medical Records are fulfilled in order as they are received. The Medical Records department will contact the requestor to collect payment before records are released. Please allow up to 30 days to receive records.

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse, or genetic test results.

I understand that this authorization will expire in one year from the date signed below unless otherwise specified.

I understand that once the information is disclosed, the information is subject to re-disclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying in writing, the CEO/Administrator of OBCCD at 840 Passover Road, Osage Beach, MO 65065, Fax: 573-693-1680.
I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____ _____

Signature of Patient or Patient's Representative | Relationship (*if not patient)* | Date/Time

If personal representative of patient signs the authorization, please indicate his/her authority to act.

CENTER FOR BEHAVIORAL HEALTH
OSAGE BEACH