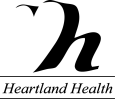
**C:\Users\staffoa\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\JO7JRY8E\mosaic black (2).png HEARTLAND HEALTH**  ****

**AUTHORIZATION FOR RELEASE**

**OF PROTECTED HEALTH INFORMATION/ACCESS REQUEST FORM**

**MRN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DECEASED PATIENT RRID\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I request protected health information (PHI) from:** 

Heartland Regional Medical Center Clinic Name/Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I request protected health information (PHI) to be released to:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize the following PHI to be released from the medical record(s):**

Emergency Room Report History & Physical Consultations

Lab Results Radiology Reports Pathology Results

EKG Radiology Films/Other Diagnostic Images Pathology Slides

Pertinent Information Complete Health Record Operative Reports

Cardiovascular Images Complete Billing Record/Itemized Bill Discharge Summary

Clinic Notes Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Covering the period of health care from:**

Specific Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ All Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose for requesting information:**

Insurance Legal Medical Law Enforcement 

Personal Research Military Department of Social Services

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby represent that I am: (please check one)**

* The agent appointed by the deceased in a Durable Power of Attorney for Health Care

or a guardian appointed for the deceased. (Please attach copy of document designated appointment.)

* The executor, administrator, or court-appointed personal representative for the deceased

patient. (Please attach copy of the order of appointment.)

* Entitled to bring a wrongful death action under Section 537.080 RS.Mo for the death of

the deceased patient and am requesting the above described medical records for purposes

of considering possible legal action under the statute. My relationship to the deceased is

(circle one): spouse child parent.

* The beneficiary of an insurance policy covering the life of the deceased patient. (Please

attach copy of the policy.)

* A devisee, legatee, or heir at law that is claiming under the deceased patient in a currently pending will contest and am requesting the above described medical records in connection

with such proceeding. (Please attach copy of the petition.)

I understand that the medical record is confidential and protected under Missouri law establishing the physician-patient privilege, and possibly under other state and federal laws. I further understand that the physician-patient privilege survives the patient’s death, and only a limited number of people may waive the deceased’s physician-patient privilege. I therefore assume the responsibility and liability for any re-disclosure of the medical record or release of any confidential information about the deceased patient.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_MRN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing this authorization form, I understand that:**

• Requests for copies of medical records and/or non-document material may be subject to copying fees.

• PHI may include records relating to mental health care, sexually transmitted diseases, Genetic/Metabolic Testing, HIV/AIDS, and/or treatment of alcohol/drug abuse.

• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Department. Revocation will not apply to information that has already been released in response to this authorization.

• Unless otherwise revoked, this authorization will expire on the following date/event/condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.

• I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this authorization, and that I can inspect or copy the protected health information to be used or disclosed.

• I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. Heartland Regional Medical Center, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization

Authorized Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of authorized representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Identification type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*If signed by a patient’s authorized representative, supporting legal documentation must accompany this authorization form\***