Regional Primary Care, Inc.

Authorization for Disclosure of Protected Health Information

Please Do Not Fax more than 20 pages: Fax (573)332-6175
Instead mail request to: 150 S. Mt. Auburn Rd., Ste. 418, Cape Girardeau, MO 63703

Date: _____

Individual Name: _____

Date of Birth: _____ Last 4 Digits SS#: _____ Phone: _____

Address: _____
Street City State Zip

I hereby authorize and request Regional Primary Care, Inc. to use and disclose my personal, private Protected Health Information including release of a copy of my medical record or a specified portion of my medical record as indicated below on this form. I understand that the information I am authorizing Regional Primary Care, Inc. to release to the person, class of persons or organization named below may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by in writing and that I may use a form furnished by Regional Primary Care, Inc. to make the written revocation. I also understand that if I revoke this authorization, my revocation will not affect any health information that was released according to the terms of this authorization before the date of my revocation. I also understand that I may not revoke authorized use and/or disclosures obtained in connection with my receipt of insurance coverage.

I understand that this authorization is voluntary, my treatment by Regional Primary Care, Inc. will not be conditioned on the completion of this authorization and I have a right to request and receive a copy of this authorization.

RELEASE TO OR RECEIVE FROM: (Please check appropriate box) ☐ **RPC to RELEASE** ☐ **RPC to RECEIVE** ☐ **NO RECORDS AT THIS TIME**

I authorize Regional Primary Care, Inc. to release or receive the information I have specified to the following person or class of persons:

Name of Physician or Facility to Release or Receive Your Records: _____

Address: _____

- ☐ This Authorization is valid for one year from the date I sign it or:
- ☐ This Authorization expires on the following date: ____/____/____ or
- ☐ This Authorization expires when the following event occurs: _____

PURPOSE OF DISCLOSURE: **Dates of Treatment:** **from ___/___/_____ through ___/___/_____** **or** ☐ **All Dates**
(check appropriate box below)

- ☐ Legal Purposes
- ☐ Permanent Transfer
- ☐ Insurance Application
- ☐ School/Daycare
- ☐ Personal Use
- ☐ Continued Medical Care (PCP)
- ☐ Other (specify) _____
- ☐ Military
- ☐ Insurance Claim
- ☐ Social Security /Disability Determination

WHAT TO DISCLOSE:
The Information I am authorizing Regional Primary Care, Inc. to disclose is (Please check record and information to be disclosed)

- ☐ Complete Records
- ☐ Radiology Reports
- ☐ Billing Information
- ☐ Physician Notes
- ☐ Immunization Records
- ☐ Other (specify) _____
- ☐ Lab Results
- ☐ Medication Records

SIGNATURE:
I have read and understand this Authorization for Release of Protected health information and I have signed it voluntarily.

X Signature of Individual or Personal Representative: _____

X Printed Name of Individual or Personal Representative: _____

Psychotherapy Notes: This authorization does not include permission to release Psychotherapy Notes. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of an Individual/s medical record. If Regional Primary Care, Inc. maintains Psychotherapy Notes concerning me, I understand that I may authorize release of Psychotherapy Notes by means of a separate authorization that will be furnished if I require it.