FITZGIBBON HOSPITAL
HEALTH INFORMATION
2305 S. Hwy. 65 • P.O. Box 250 • Marshall, MO 65340
Phone: (660) 831-3227 • Fax: (660) 831-3315

Authorization for Fitzgibbon Hospital to Release Medical Information

I hereby authorize FITZGIBBON HOSPITAL and the affiliated healthcare provider(s) (*select all that apply*):

- ☐ Marshall Family Practice
- ☐ Marshall Surgical Associates
- ☐ Marshall Women's Care
- ☐ Fitzgibbon Chiropractic
- ☐ Fitzgibbon Mental Health
- ☐ The Living Center
- ☐ Community Cancer Center
- ☐ Cardiac Wellness Center
- ☐ Home Health/Hospice
- ☐ Marshall Orthopedic & Sports Medicine
- ☐ Outpatient Clinic _____
- ☐ Missouri Valley Physicians
- ☐ Akeman-McBurney Medical Clinic *(Slater)*
- ☐ Fitzgibbon Family Health *(Fayette)*
- ☐ Grand River Medical Clinic *(Brunswick)*
- ☐ Mid-Missouri Family Health
- ☐ Pilot Grove Medical Clinic *(Pilot Grove)*
- ☐ Other:_____

to RELEASE copies of certain medical record information as specified below:

Patient's Full Name:_____ Date of Birth:_____

Address:_____

Phone No.:_____ Last 4 Digits of Social Security No.:_____

I request ONLY the following information be RELEASED FROM Fitzgibbon Hospital/affiliated provider:

- ☐ Entire Medical Record
- ☐ Emergency Report
- ☐ Discharge Summary
- ☐ EKG
- ☐ History & Physical
- ☐ Laboratory (*specify*)_____
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ Itemized Billing Statement
- ☐ Other _____

Date(s) of Treatment: ☐ All ☐ Only for the date(s) specified here:_____

PSYCHIATRIC, DRUG AND/OR ALCOHOL ABUSE, HIV/AIDS RECORDS RELEASE: I understand if my medical or billing record contains information *in reference to*:

☐ Yes ☐ No a) *psychiatric testing and/or treatment*, I agree to its release

☐ Yes ☐ No b) *drug and/or alcohol abuse, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information*, I agree to its release

☐ Yes ☐ No c) *HIV/Aids testing and/or treatment*, I agree to its release

Information is to be released to:

- ☐ Self
- ☐ Other_____ *(ex., spouse, parent, attorney etc.)*
- ☐ Physician/Clinic/Hospital - name of facility contact person *(if known)*_____

Name:_____

Address:_____

Phone No.:_____ Fax No.:_____

Email Address:_____

For the purpose of *(optional)*:_____

I would you like the records delivered? ☐ Paper: ___to be mailed ___to be picked up
☐ Electronically: ___secured/encrypted email ___CD ___fax

I UNDERSTAND that I can revoke this authorization at any time prior to action being taken. I understand this authorization will expire one (1) year from the date it is signed. I understand that if I want to cancel/revoke this authorization, I must mail, fax or bring a letter in person to the address or fax listed at the top of this form, stating that I want to cancel this authorization.

I UNDERSTAND that neither Fitzgibbon Hospital, nor any of its affiliated healthcare providers, can make me sign this agreement as a condition to obtaining medical treatment.

PROHIBITION ON REDISCLOSURE: Once this information has been released pursuant to this authorization, it may no longer be protected by federal and/or state law/regulations and may no longer be deemed confidential. I permit the release of all information indicated above to include test results, diagnoses, and treatment information. I understand the information released may include psychiatric treatment, may indicate the presence of AIDS/HIV or other communicable diseases, drug and/or alcohol usage, or drug and/or alcohol treatment.

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If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must produce a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must provide a certified copy of the patient's death certificate.

X _____ _____ _____

Signature of Patient / Legal Guardian / Personal Representative | Date | Time

_____

If someone else signs on behalf of the patient, state your relationship (mother, father, etc.) to the patient

_____ _____ _____

Witness Signature | Date | Time

_____

Witness Print Name

This authorization is being presented pursuant to litigation: ☐ Yes ☐ No

If this Authorization is being presented pursuant to litigation, complete this section.

If this Authorization is being completed pursuant to litigation, please note that this Authorization includes medical records, reports, and other medical documents in your possession which relate to any prior or subsequent complaints, injuries, illnesses, or other conditions involving the same parts of the body and the same or similar conditions as described below. This Authorization includes, but is not limited to, records of all examinations, treatments and tests, including inpatient, outpatient, and emergency room, whether for diagnostic or prognostic purposes, consultation reports, correspondence, x-rays, photographs, videotapes, MRIs, and CT scans and post-mortem records, if applicable, provided that the examinations, treatments, and/or tests involve or relate to complaints, injuries, illnesses, or conditions pertaining to the following alleged injury:

_____

(insert allegation from petition which describes injured part(s) of body)

The healthcare provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above-referenced care. The decision to enter into any such conversation is that of the healthcare provider. However, disclosure that exceeds the scope of this authorization may subject the healthcare provider to civil liability.

This authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required.

The patient further requests that the healthcare provider supply complete copies of all documents produced pursuant to this authorization to patient's attorneys, _____, at their expense (if desired by Plaintiff's counsel).

Date/Time of Release:_____ _____ am / pm

Release of Information Clerk:_____

REVOCATION

I hereby revoke this Authorization for Release of Information immediately. I understand that the health information may already have been disclosed pursuant to and in reliance on my prior authorization. I also understand that this revocation applies only to the information specifically described herein, and does not affect any prior executed consents to release information for treatment, payment or healthcare operations, or any prior Authorizations for other information.

X _____ _____ _____

Signature of Patient / Legal Guardian / Personal Representative | Date | Time

_____

If someone else signs on behalf of the patient, state your relationship (mother, father, etc.) to the patient

_____ _____ _____

Witness Signature | Date | Time

_____

Witness Print Name