



Pike County Memorial Hospital
 2305 Georgia Street
 Louisiana, MO 63353
 Ph: 573-754-5531

Louisiana Clinic
 2305 Georgia Street
 Louisiana, MO 63353
 ph: 573-754-4584
 Fax: 573-754-5280

Bowling Green Clinic
 1015 W. Adams St.
 Bowling Green, MO 63334
 ph: 573-324-5300
 fax: 573-324-6059

Vandalia Clinic
 425 N. Galloway Rd.
 Vandalia, MO 63382
 ph: 573-594-2111
 fax: 573-560-5527

Walk-In Clinic
 1420 S. Business 61
 Unit F.D.E.
 Bowling Green, MO 63334
 ph: 573-324-5562
 Fax: 573-324-2567

AUTHORIZATION TO DISCLOSE INFORMATION TO INDIVIDUAL

PATIENT NAME: _____ DATE OF BIRTH: _____

Many of our patients allow family or other individuals to have access to their Protected Health Information (PHI). This information could include appointment, billing, and/or medical and diagnosis information. In accordance with Federal privacy rules implemented through the Health Insurance Portability and Accountability Act of 1995 (H.I.P.A.A.), we are not allowed to release this information without your written consent. If you wish to have your PHI released to family, friends, or other individuals you must consent by signing this form. Only individuals listed on this form will be allowed access to your PHI at Pike County Memorial Hospital and Clinics, as described below. This form is not required for treatment. A separate form is required for Mental Health and HIV related diagnosis. This form DOES NOT EXPIRE, but access can be revoked at any time by completing a Revocation of Access form.

I, the above named patient, authorize Pike County Memorial Hospital and Clinics to release my PHI to the individual(s) listed below:

1. Name: _____ DOB: _____
 Relation to Patient: _____ Contact phone number: _____
 This individual is allowed to pick up/receive copies of my PHI (circle one): Yes No
 Type of Information I consent to be released (check all that apply):

- Appointment Billing
- Medical or Diagnosis All Information

2. Name: _____ DOB: _____
 Relation to Patient: _____ Contact phone number: _____
 This individual is allowed to pick up/receive copies of my PHI (circle one): Yes No
 Type of Information I consent to be released (check all that apply):

- Appointment Billing
- Medical or Diagnosis All Information

GRANT ANOTHER PERSON ACCESS TO YOUR PATIENT PORTAL

I wish to allow one of the individuals listed above access to my Patient Portal. Below is their email address and last 4 digits of their social security number. (If you do not wish to grant access, skip this section.)

Email: _____ Last 4 of SSN: _____

I understand that I have the right to revoke this authorization at any time (as described above) and that I have the right to inspect or request a copy of the PHI that has been disclosed.

I understand that once the PHI is released to the individual(s) above, the PHI is no longer protected by Federal or State law and could be subject to re-disclosure by the above recipient.

 Printed Patient Name Patient Signature Date