PIKE COUNTY MEMORIAL HOSPITAL & CLINICS
Louisiana, Missouri

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 FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

PATIENT NAME:_____BIRTHDATE:_____
LAST FIRST MI (MM/DD/YYYY)

ADDRESS:_____
STREET CITY STATE ZIP CODE

FORMER NAMES:_____ PHONE #:_____

EMAIL (if records are to be sent via email):_____

I authorize Pike County Memorial Hospital & Clinics to: ☐OBTAIN RECORDS FROM OR ☐RELEASE RECORDS TO

_____
Name and Address of Person, Agency, or Institution

These records are for Doctor/Provider:_____ for the purpose of (circle one): Continuation of Care Other

This consent is confined to records regarding admission/treatment for the following:

Date(s) of Service:_____

Medical Condition/Injury:_____

☐Emergency Room Record
☐Discharge Summary
☐History & Physical
☐Physical Therapy
☐Operative & Pathology Reports
☐Other:_____
☐EKG Report
☐X-Ray Report
☐MRI
☐Ultrasound
☐Mammogram
☐Lab Reports
☐Radiology Films/Images
☐CT Scan
☐Consultation Report

Specific Authorization for Release of Information Protected by State or Federal Law

Be advised that Federal Regulation 42 CFR Part 2, specifically prohibits re-disclosure of this information.
I specifically authorize the release of data and information relating to (Check the appropriate box):

☐ **Substance Abuse** ☐ **Mental Health** ☐ **HIV-Related Information** ☐ **Reproductive Health**

_____ _____
Patient Signature **Date**
In order for the above information to be released, you must sign here AND below.

_____ _____
Patient Signature (ID required) Date signed

_____ _____
Signature of Parent/Guardian/Power of Attorney, if applicable Date Signed

_____
Employee/Witness Signature □ Identification Checked

For Office Use:
FIN:_____

****This authorization will expire in 90 days or upon written request****

Scan: Patient, Release of Information
Level Document Type

Revised: 1/17/2025