



**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**

<b>Person Requesting Disclosure:</b>	<b>CIRCLE ONE: SEND PHI TO OR RECEIVE PHI FROM</b>
Name	Name of Physician(s), Attorney, Agency, etc
Address	Address
City/State	City/State
Phone #:	Phone #:
<b>Information contained in the medical record of:</b>	
Patient's Name	Birth Date
Related to medical care and treatment provided to the above-name patient for the purpose of (e.g., transfer of care, second opinion, patient treatment, other)	

I authorize the following protected health information to be released and understand that my records may reference sensitive information including, but not limited to, mental health diagnoses/treatment, sexually transmitted infections, drug/alcohol abuse and HIV.

**Please select the type of information you are authorizing for release:**

- Office Visit notes       Laboratory reports       X-ray reports       Consultation reports
- Operative reports       Pathology reports       CT/MRI reports       Physical Therapy notes
- History & Physical       Radiological Images       Ultrasound reports       Mammogram reports
- Discharge Summary       Emergency Room records       Other: \_\_\_\_\_

Specific dates: from \_\_\_\_\_ to \_\_\_\_\_. If no date is provided, protected health information for the two-year period prior to the date of this authorization will be released. We will not accept a release for future medical records.

**I authorize Pike County Memorial Hospital & Clinics to release sensitive information as indicated:**

- HIV/AIDS       Drug/alcohol/substance abuse       Behavioral/Mental health       Reproductive Health
- Sexual assault

Initials of Patient/Authorized Agent consenting to the above sensitive information being released: \_\_\_\_\_

**Select how you would like this information released:**  In-person Pickup     US Mail     CD

Secure email: \_\_\_\_\_  Fax: \_\_\_\_\_

**NOTE:** Per Missouri Law §632.155 RSMo, minors age 16 and older, who consent to mental health treatment must consent to the release of those records. Per Missouri Law §631.155 RSMo, minors age 12 and older who consent to substance abuse treatment must consent to the release of those records. Per Missouri Law §167.640 RSMo, any minor consenting to reproductive health treatment must consent to the release of those records.

By signing below, I understand the following provisions:

- I understand that this authorization/consent is voluntary and that I may refuse to sign this authorization/consent. Unless allowed by law, my refusal to sign will not affect my ability to receive treatment.



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- I understand that I have the right to cancel this authorization at any time, **in writing**, and must deliver the revocation/cancellation to the Pike County Memorial Hospital Health Information Management Department.
- I understand that the revocation will not apply to information that has already been released in response to this authorization. Any disclosure/sharing of information has the potential for an unauthorized re-disclosure by the recipient and it would no longer be protected by law.
- For any mental health information, only records of services up to the date of the signature on the authorization will be released while non mental health records will be released including service dates after the signature but before expiration.
- I may inspect or receive a copy of the information to be used or disclosed as provided by law.

This authorization expires in 90 days, unless otherwise specified here: \_\_\_\_\_.

Signature of Patient or Authorized Individual		Date
If Signature is not of Patient, Indicate Relationship:		Date
Signature of Witness	Title	Date