Authorization for Release of Medical Records

Lincoln County Health Department
5 Health Department Drive
Troy, MO 63379
Phone: 636-528-6117 Fax: 636-528-8629

Client Information:

Client Name: _____ _____ _____ _____
(Last) (First) (Middle) (Maiden Name)

DOB: _____ Social Security: _____ and/or DCN#: _____

Address: _____ _____ _____ _____ _____
(Street) (City) (State) (Zip) (Phone)

I would like the following records (check all that apply):

- ☐ Test Results (i.e. PPD/TB Results, Pap Results, Lab Results)
- ☐ Entire medical record
- ☐ STD Results
- ☐ Immunization Record
- ☐ Billing
- ☐ Dental Models
- ☐ Proof and date of last Depo Provera
- ☐ Medical Records from _____ (Date) to _____ (Date)
- ☐ HIV test results. Date of HIV test: _____
- ☐ Dental Treatment Plan
- ☐ Dental X-Rays
- ☐ Other

To be released to the following (circle one): School/Physician/Hospital/Clinic/Person: _____
(Person or Facility Authorized to Receive Records)

By (please check all that apply) ☐ Mail ☐ Fax ☐ Pickup ☐ E-Mail

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Phone#: _____ Fax#: _____ E-Mail Address: _____
(For Doctors or Other Healthcare Providers)

The purpose of this disclosure is: _____AT THE REQUEST OF THE PATIENT _____TO CONTINUE PATIENT CARE _____OTHER

I understand that at any time I have the right to revoke this Authorization pursuant to Lincoln County Health Department's Notice of Privacy Practices, except to the extent that Lincoln County Health Department has already used or disclosed your information in reliance on this Authorization. I understand that I may revoke this Authorization by contacting Mende Kemper, RN. I understand that once information leaves Lincoln County Health Department, Lincoln County Health Department no longer directly controls the information. It is therefore possible that information used or disclosed under this Authorization could be re-disclosed by the recipient and no longer be subject to privacy protections provided by law. I understand that I am not required to sign this Authorization and that my healthcare and payment for care will not be affected by my refusal. I am aware that a copy of this authorization may be utilized with the same effectiveness as an original.

If your child will be accompanied by someone other than you to their appointment, please indicate their name and relationship below. By listing them, you are giving Lincoln County Health Department permission to discuss your child's medical information and release their medical records to them.

Name of Person (First and Last name)	Relationship
1._____	_____
2._____	_____
3._____	_____

_____
Patient's/Representative Signature

_____
Date Signed*
*This release of information expires one year after the date of signature.

_____
Name of Representative (print)

_____
Relationship to Patient