Important Information For Our Patients:

Disclosures of Protected Health Information Requiring Your Authorization:

Most disclosures of your protected health information that are not part of treatment, payment, or operations require specific authorization by you or your personal representative. Such authorizations must include a description of the information to be disclosed, who is authorized to make the disclosure, who is authorized to received the disclosure, the purpose of the disclosure, an expiration date or event related to the disclosure, a dated signature by the subject of the disclosure or a personal representative, and, if signed by a representative, a description of his or her authority to act on your behalf. If you request the disclosure, you may indicate "at the request of the individual" as the reason for the disclosure. Any authorizations we initiate will be written in plain language, will list the specific reason for the request, and will inform you that you can revoke the authorization in writing. You will be provided a copy of any disclosures we initiate. Protected health information that is disclosed to a third party potentially may lose its protection against redisclosure.

Authorizations we receive that are lacking essential elements are considered invalid under The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and will not be honored.

If you have any questions about the enclosed "Authorization to Disclose Protected Health Information" you may contact our office at 573-876-1618.

Thank you.
Medical Network Technologies, LLC
Medical Records Department
401 Keene Street
Columbia, MO 65201

Med Rec #:_____

Authorization to Disclose Protected Health Information

In order to provide for your healthcare, **Dr. _____ (Physician)** collects information about your medical history, physical examinations and test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, healthcare providers must obtain a valid authorization in order to release any such information to a third party for purposes not related to your treatment, receiving payment, or healthcare operations. This authorization gives **Physician** permission to disclose the elements of your protected health information listed below for the specified purposes to the stated recipient.

I understand that I am not required to sign this authorization, and that my treatment is not conditioned on signing, except as described below. A copy of this authorization will be provided to me if **Physician** initiated the request for this authorization.

Exceptions: **Physician** may condition treatment on signing an authorization for disclosure to a third party if the sole reason for treatment is for disclosure to that party (e.g., a physical being paid for by an insurance company in order to determine eligibility for a policy). Also, provision of treatment that is part of a research study may be conditioned on an authorization to disclose protected health information as required for the conduct of the clinical trial.

Therefore, I, _____ (patient or personal representative), consent that **Physician** may disclose the following health information of
(check one) ☐ myself or ☐ (specify:) _____
(*If signing as a personal representative, documentation of your legal right to do so must be provided.*)

Specific health information to be disclosed, including date(s).
_____
_____

Purpose for which the authorization is being requested If the patient or a personal representative is making the request, the purpose can be stated as "at the request of the individual" if he or she does not wish to disclose the purpose. Otherwise, a purpose must be specified.
_____
_____

The health information requested is to be disclosed to:

Recipient _____

Address _____

City _____ State ____ Zip code _____

This authorization will remain valid until ___/___/20___ or until the following event related to this authorization takes place: _____, after which time it will become invalid.

I understand that protected health information released to a third party that is not subject to HIPAA regulations will no longer be protected, and may be subject to redisclosure. Only providers of healthcare (organizations that provide medical or health services or medical supplies), health plans (organizations that pay for medical care), and healthcare clearinghouses (organizations that convert health data into the required format for electronic transmittal) are covered by HIPAA I understand that I may revoke this authorization in writing at any time, but that this revocation will not affect any prior authorized disclosures that have been taken by **Physician**.

_____	___/___/20___	_____	_____
Signature of Patient or Personal Representative	Date (mm/dd/yyyy)	Printed Name	Relationship to Patient (if not self)

Patient Date of Birth: _____ Patient Soc Security #: _____

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired Immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Patient or Personal Representative must initial here _____ if disclosure of the information referenced above can be released.