OHA
ONCOLOGY HEMATOLOGY ASSOCIATES
OUR PASSION IS YOUR LIFE

3850 S. National, Suite 600 • Springfield, Missouri 65807 • 417-882-4880 • Fax 417-882-7843

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #: _____ Telephone: _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

From (date) _____ to (date) _____

Please Check Type of Information to be Released:

❑ Complete Health Record ❑ Hospital Records ❑ Lab Results ❑ Radiology CD/Films
❑ New Patient Evaluation ❑ Medication List ❑ Pathology Results ❑ Pathology Slides
❑ Progress Notes ❑ Chemo Flow Sheets ❑ Radiology Results ❑ Itemized Bill ❑ Complete Billing Record
❑ Other (specify) _____

Purpose of Request

❑ Treatment or Consultation ❑ At the Request of the Patient ❑ Billing or Claims Payment

❑ Other (specify) _____

I, the undersigned authorize and request OHA to ____ Release Information to ____ Obtain Information from

Name: _____

Address: _____ Phone: _____

_____ Fax: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or sensitive information, I agree to its release.

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at 3850 S. National, Suite 600, Springfield, MO 65807. Unless revoked, this authorization will expire on the following date or event _____, or one year from date of signature, unless otherwise specified.

Re-disclosure
I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize OHA to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Authority to Sign if not patient: _____ Date: _____