South Central Missouri Community Health Center
DBA Your Community Health Center
1081 East 18th Street
Rolla, MO 65401
573-426-4455
Fax 855-507-9273

Request for Release of Medical Information to Your Community Health Center

To:

Physician or Facility	
Address	
City, State, Zip	
Fax	

Our Mutual Patient has requested that you share their medical information with us in order to better meet their medical care needs.

It would facilitate entry of this information into our medical record system if the requested information was faxed to 855-507-9273

Patient	
DOB	
Our Medical Record #	
Date of Our Request	

For Internal Use	
Date Request Fulfilled (internal use)	

Authorization to Release of Medical Information to

Your Community Health Center

I, _____, with a date of birth, _____, give my permission for

_____ to give my medical records (as described below) to **Your Community Health Center** so its care providers can better understand my condition and help me.

Permission to get sensitive information

By putting my initials by each item below, I understand that I can give permission for records to be sent that may contain information about:

_____ my mental health,
_____ transmittable disease I may have like HIV/AIDS,
_____ genetic records, and/or
_____ drug and alcohol records.

I understand that:

I do not have to give my permission to share these records.

If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.

This form is only good for 3 months from the date I sign it.

Patient's Signature: _____ Date: _____

Authorized Signature: _____ Date: _____

Relationship of Authorized Representative: _____

Consent for medical records for _____

Date: _____

Types of records we are requesting:

___ Any and all types of records you have for this patient
___ Doctor Visit Notes
___ Emergency Room Rates
___ Urgent Care Notes
___ History and Physical
___ Hospital Progress Notes
___ Operation or procedure notes
___ Clinic Notes
___ Pathology reports
___ Doctors Orders
___ Nurses Notes
___ Discharger Summary
___ Lab Reports
___ Radiology Reports
___ Consultations
___ Other

Records within the following dates:

___ All records for this patient

Records dated between _____ and _____

Please send records to Your Community Health Center

Attention: __Kassandra Troutt, Officer Manager

We prefer that you Fax records to: 855-507-9273

Or mail to:

Your Community Health Center
1081 East 18th Street
Rolla, MO 65401

For any questions please call 573-426-4455