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

Authorization to Release of Medical Information FROM Your Community Health Center

I, ________________________, with a date of birth, _______________, give my permission for

Your Community Health Center to give my medical records (as described below) to __________________________ 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:
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
___ History and Physical
___ Operation or procedure notes
___ Clinic Notes
___ Pathology reports
___ Doctors Orders
___ Nurses Notes
___ Lab Reports
___ Radiology Reports
___ Consultations
___ Other

Records within the following dates:
___ All records for this patient
Records dated between ________________________ and ______________________________

Please send records to:

☐ To Physician or Facility

Physician or Facility	
Address	
City, State, Zip	
Fax	

☐ To Me