



REQUEST FOR RELEASE OF MEDICAL INFORMATION PLATTE COUNTY HEALTH DEPARTMENT

212 Marshall Road
Platte City, MO 64079
(816) 858-2412 Fax: (816) 858-2087

1201 East Street
Parkville, MO 64152
(816) 587-5998 Fax: (816) 587-6028

Name: _____ SS#: _____ DOB: _____

Address: _____

For the purpose of continuing medical care, I request medical information from:

(Hospital/Physician/Health Department)

(Address)

Requested information: _____

Specific permission is required to release the following information. Please initial if this information is to be included:

- ____ I authorize release of alcohol/drug abuse treatment and information.
____ I authorize release of HIV test results/treatment information.
____ I authorize release of psychiatric information.

I want this information released to:

(Hospital/Physician/Health Department)

(Address)

This authorization may be revoked in writing at any time and expires in one year.

Signature of Patient or Authorized Representative

Date

Printed Name

Witness

____ Primary Care ____ Family Planning ____ Immunizations ____ WIC