Mitchell C. Mullins DO
Missouri Independent Medical Evaluations, LLC
Missouri Life Care Plans
Board Certified Emergency Medicine
Certified Life Care Planner

Authorization for the Release of Health Information

Release FROM:

Name: _____
Address: _____
City/St/Zip: _____

Release TO:

Name: Dr. Mitch Mullins
Address: 1801 W. Norton Rd., Ste. 100
City/St/Zip: Springfield, MO 65803

Patient Identification:

Name: _____
Address: _____
City/St/Zip: _____

Social Security #: _____
Date of Birth: _____

___ *I will review the records at the facility*
___ *I wish to have the facility fax the following records to the number provided.* **417-833-5489**
___ *I am requesting that the facility e-mail the files to* ***drmullins@MIME-LCP.com***
___ *I wish to have the following records placed on disk and mail to the address above.*

I am requesting the following records from the individual's medical record that were created between_____/_____/_____and_____/_____/_____.

___ Complete Health Record ___ER Records ___Lab Results ___History & Physical
___ Discharge Summary ___Radiology Report ___Rehab Notes ___Operative Notes
___ Other: _____

Purpose for Use of Records:

___ Treatment ___At the request of the patient ___Billing or claims

NOTE: *This authorization will expire one year from the date of signature.*

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Signature: _____ Date: _____