SAINT LOUIS MEDICAL CLINIC

Authorization to Obtain Medical Records

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Print Patient's Full Name **Date of Birth**

Name of Facility/Physician: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

I hereby authorize St. Louis Medical Clinic or a representative to obtain the following medical information:

_____ Designated Record Set From _________ To _________

_____ Admission/Discharge Summary From _________ To _________

_____ Immunization Record

_____ Mental Health Notes

_____ Laboratory Records From _________ To _________

_____ X-Ray films and report(s) From _________ To _________

_____ Mammogram(s) and report(s) From _________ To _________

_____ Entire Medical Record

_____ Other (Must be Specified) ______________________________

This authorization is given freely with the understanding:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without prior written authorization.
2. A photocopy or fax of this authorization will be as valid as the original.
3. I may revoke this authorization at any time, except where information has already been obtained. This authorization is valid for a ninety (90) day period from the date it is signed.

Release or Mail to: **St. Louis Medical Clinic, P.C.**
3009 N. Ballas Road, Suite 100B
St. Louis, MO. 63131
Telephone: (314) 432-1111 **ATTN Dr.** ______________________

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Patient's Signature or Guardian, if a minor **Date**

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Patient's Address **City, State, Zip Code**