

314-432-7317-(FAX)

SAINT  
LOUIS  
MEDICAL  
CLINIC

Authorization to Release Medical Records

Print Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

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

Name of Facility/Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

This authorization extends to only documents initialed below:

\_\_\_\_\_ Designated Record Set From \_\_\_\_\_ To \_\_\_\_\_

\_\_\_\_\_ Admission/Discharge Summary From \_\_\_\_\_ To \_\_\_\_\_

\_\_\_\_\_ Immunization Record

\_\_\_\_\_ AIDS(Acquired Immunodeficiency)/HIV (Human Immunodeficiency Virus) Information (**Only release to pt**)

\_\_\_\_\_ Mental Health(including depression) or alcohol/drug abuse treatment (**only release to patient**)

\_\_\_\_\_ X-ray films and report(s) \_\_\_\_\_ Mammogram(s) and report For the purpose of \_\_\_\_\_

\_\_\_\_\_ Other (Must be Specific) \_\_\_\_\_ Genetic Testing (**only to patient**) \_\_\_\_\_

\_\_\_\_\_ Entire Medical Record \_\_\_\_\_ Statement of charges or payments

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.
4. St. Louis Medical Clinic, 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.
5. St. Louis Medical Clinic contracts with Healthport to provide copies of medical records. Healthport will send an invoice directly from their home office for any charges associated with your copies.

Please print patient name

Date

Patients Signature (or Guardian if minor)

Patients Date of Birth

Witness

Date