NEUROSURGERY of St. Louis

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION BY RELEASE OF MEDICAL RECORDS

REQUEST RECORDS FROM:	PLEASE SEND THE RECORDS TO:
Names: _____ Address: _____ City:_____ State: _____ Zip: _____ Phone: _____ Fax: _____	Neurosurgery of St. Louis Walker Medical Building (North Tower) 12855 North Forty Drive, Suite 125 Saint Louis, MO 63141-8635 Phone: 314.806.1770 Fax: **314.558.9017**

PATIENT INFORMATION:

Patient Name: _____ Social Security Number:_____
Address: _____
City:_____ State: _____ Zip: _____
Phone#: _____ Fax: _____ Date of Birth: _____

I, _____, authorize the above listed person/s, physician/s, firm or entity (or its Agents, representatives, or employees) to release for inspection and copying, any and all of the Personal Health Information (PHI) listed below that pertain to my treatment, hospitalization, or care from the date/s of: _____ to _____.

☐ **Entire Record-Inpatient**	☐ **Radiology/X-ray Reports**	☐ **Operative Reports**	☐ **Pathology Reports**
☐ **Entire Record-Outpatient**	☐ **Laboratory Reports**	☐ **ER Records**	☐ **Discharge Summary**

☐ **Other: _____**

REASON FOR REQUESTING RELEASE:

☐ Relocating ☐ 2nd Opinion ☐ Continuity of Care (PCP)

☐ Transfer of Care To_____ ☐ Other_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ I DO NOT WANT HIV OR MENTAL HEALTH INFORMATION RELEASED.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date (below) it is initiated.

Please Note: Copy Fee May Be Charged for Medical Records

The Patient's Authorization below confirms his/her agreement for this Disclosure of his/her PHI. Once completed, signed Authorization is received in our office, please allow up to 48 hours for processing request. A photocopy of this Authorization will have the same effect and force of an original.

Authorization of Patient or Personal Representative: _____ Date: _____

Patient's Printed Name:_____