		Health Information Management Center for Specialized Medicine 1225 S Grand Blvd, Garden Level St Louis, MO 63104-1016 314-977-6017

Authorization to Obtain Patient Information

I hereby authorize Saint Louis University Medical Group to obtain information from:

____
Doctor or Hospital

____
Address (Street, City, State, ZIP code) Phone number

The following information from the clinic records on:

____
Patient's Name Previous Names Birth Date Social Security Number

For the purpose of: ____

Information to be released:

Date(s) of Service: ____

_____ Progress Notes
_____ History and Physical
_____ Discharge Summary
_____ Radiology Reports
_____ Laboratory Reports
_____ Operative Reports
_____ Physicians Orders
_____ Entire Record
_____ Specific Information: ____

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I understand that the specific information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). I authorize the release of this specific data. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation.

This authorization expires six months from the date of signature, unless I specify otherwise or revoke my authorization. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations.

I have read and understand this consent and I have signed it voluntarily and of my own free will.

____ _______________
Signature of Patient or Parent/Executor/Legal Representative Date

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Relationship to Patient