

**SAINT  
LOUIS  
MEDICAL  
CLINIC**

**Authorization to Obtain Medical Records**

---

**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.** \_\_\_\_\_

---

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

**Date**

---

**Patient's Address**

**City, State, Zip Code**