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**