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**