SAINT LOUIS
Rheumatology
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ **Date of Birth** _____

I Authorize _____ to use or release/disclose my health information as described below.

- O Entire Record
  Or (choose appropriate categories to be released)
- O Problem List
- O Medication List
- O List of Allergies
- O Immunization Record
- O Most Recent History
- O Most Recent Discharge Summary
- O Lab Results (Please Describe) _____
- O X-RAY or Imaging (Please Describe) _____
- O Consultation Reports (Please supply Dr.'s Name) _____
- O Other (Please Describe) _____

The Identified Information will be used for the following purpose:

- O Personal Records
- O Sharing with other Healthcare Professionals
- O Other (Please Describe) _____

The Information may be used by or released to the following individual or organization:

Name _____

Address and/or Fax _____

By Signing below, you acknowledge that information in my health record may include information related to AIDS, HIV, behavioral health and mental health services. I also understand that the information may be re-released by the recipient and the information may not be protected by federal privacy laws or regulations. I understand I have the right to revoke this authorization at any time and if I do so, I must notify the practice in writing about the revocation. The revocation does not apply to information already disclosed nor does it apply to my insurer who has lawful authority to request information for claims processing or contestation. The authorization expires on ____/____/____ or twelve months from the date signed if no expiration is given.

I understand that there is a charge for records disclosed to anyone other than a healthcare professional associated with my care. A charge will apply to any records released to the patient or patient's representative(s).

_____ _____
Patient Signature (or Patient Representative) Date Signed

_____ _____
Printed Name of Patient Representative if not signed by Patient Relationship to Patient