Authorization of Release of Medical Records

This form must be completely filled out in order to process your records.

To release information from the records of____
(Patient Last Name) (First Name) (MI)

I (the undersigned)authorize:____

(Street) (City/State) (Zip) (phone #)

Date of Birth____________________Soc Security #______________________________

2. Information is to be released to: Women to Women Healthcare
8888 Ladue Road Suite 220
St. Louis, MO 63124
Ph. (314) 644-3336 Fax: (314) 644-5606

3. Purpose of Disclosure:____
4. Information to be released, (a clear meaningful reason is required by law)

Date of Accident/Injury:______________Injuries sustained______________________________
Check all that apply:
__Record of Visits___Progress Notes___Consultation Reports___Diagnostic Tests___Billing Records
__X-ray Reports/Films__Lab Results___History & Physical___Ekg's___Operative Procedure Report
__Discharge Summary__Other (must be specific)______________________________________
Dates to be released:____

5. I understand I may have a copy of this authorization and this consent may be revoked in writing at anytime. To inititate revocation of this authorization direct all correspondence to the person named above in section 3.

6. PLEASE INITIAL ANY OF THE FOLLOWING THAT APPLY:
__No, I DO NOT authorize you to release information concerning mental health problems such as phobias, depression, anxiety, attention deficit disorders, etc.
__No, I DO NOT authorize you to release any and all medical records in your possession related to a diagnosis or treatment of HIV or AIDS, or Sexually Transmitted Diseases or any ailment related thereto.
__No, I DO NOT authorize you to release any information concerning alcohol and/ or drug abuse treatment.

7. This authorization is valid for a 90-day period form the date it is signed, if an expiration date is not provided.
Expiration Date______________________

8. I understand my records may be copied by a service and there may be a fee charged that I will be Responsible for paying. A photocopy of this authorization is as valid as the original.

9. I understand that the information used of disclosed pursuant to the authorization may be subject to Re-disclosure by the recipient and may no longer be protected by Federal Law.

SIGNATURE:_____________________________________DATE__________________
Patient of personal legal representative (next of Kin of legal guardian to sign only if patient is a minor
If legally incompetent or deceased documentation must be attached showing legal representation)

PRINT NAME:____________________________________

Relationship to Patient:__________________________________