Authorization for Release of Protected Health Information

Patient Identification

Printed Name _____ Date of Birth _____

Address _____ SSN _____

_____ Telephone _____

Information is to be released by:

_____
(Physician or Facility)

_____
(Street Address)

_____
(City, State, Zipcode)

_____
(Telephone Number)

Information is to be sent to:

Arthritis Consultants, Inc

ATTN: Dr. [] Ross [] Ince [] Dehlendorf

522 North New Ballas Road Suite 240
St. Louis, MO 63141

314-567-5100

Information to be released - Covering the periods of health care

From (date) _____ to (date) _____

Please check type of information to be released:

____Complete health record _____Discharge summary _____X-ray films/images/reports ____Laboratory test results
____Other (specify) _____

Purpose of Request:

____Treatment or consultation _____At patient request ____Other (specify) _____

Drug and/or Alcohol Abuse and/or Psychiatric and/or HIV/AIDS Records release

I understand that if my record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing and/or other sensitive information, I agree to its release **Check one:** Yes [] No []

Time Limit and Right to Revoke authorization

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Medical Records Department or other department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event _____, or 90 days from date of signature unless otherwise specified.

Re-release

I understand that the information released pursuant to this Authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. This facility, 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.

Signature of Patient or Personal Representative Who May Request Disclosure

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. By signing below, you authorize your provider, identified above, to release your protected health information as specified above.

Signature_____ Date_____

Authority to sign if not patient _____Witness_____