Authorization for Release of Medical/Health Information

Name of Patient: _____ Date of Birth: _____

SSN: _____

Name of Person Completing this form, if other than the Patient:

_____

(Name) *(Relationship to Patient – Parent, Guardian, Etc.)*

I hereby authorize and request that:

☐ Miriam Schroeder, MD; 3115 South Grand Blvd Suite 450; Saint Louis, MO 63118;
Phone 314-594-7047, Fax 888-366-3261

Release the Below Specified Information to:

_____

(Name) *(Address)*

_____

(Phone Number) *(Fax Number)*

☐ _____

(Name) *(Address)*

_____

(Phone Number) *(Fax Number)*

Release the Below Specified Information to:

Miriam Schroeder, MD; 3115 South Grand Blvd Suite 450; Saint Louis, MO 63118;
Phone 314-594-7047, Fax 888-366-3261

The purpose of this disclosure is (check all that apply):

☐ Assessment and Diagnosis ☐ Continuity of Care

☐ Other: _____

The Specific Information to Be Disclosed is (check all that apply):

☐ Mental Health and/or Substance Abuse Records

☐ Inpatient Records
☐ Outpatient Records
☐ Emergency Department Records

☐ Admission/Intake Note(s) *(H&P, Med/Psych Assessment, etc.)*
☐ Progress Notes
☐ Discharge Summary

☐ Laboratory or Diagnostic Testing Results: _____

☐ Other _____

From the Time Period of: _____

Authorization for Release of Medical/Health Information

READ CAREFULLY:

1. I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.

2. Alcohol and drug abuse information are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. **PLEASE SIGN IF YOU ARE AUTHORIZING THE RELEASE OF ALCOHOL AND DRUG ABUSE INFORMATION:**

_____

3. This authorization applies to both information presently compiled and future information to be compiled during the course of treatment by the above-named facility, agency, or provider(s) during the time period prior to this authorization's expiration.

4. This authorization becomes effective on the date signed as indicated below. This authorization will automatically expire one year from the date signed, unless I specify an earlier expiration date as may be noted here: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) of the entities named on side one of this form. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.

6. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**

7. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director), or client information center, or designee, or the Privacy Officer for this covered entity.

THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS:
Prohibition of the Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

_____ _____

(SIGNATURE) (DATE)