Authorization to Release Medical Records

Name of Patient ______________________________ Date(s) of Service ___________________

Date of Birth __________________ Social Security Number ______________________

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

× Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other: ______________
Legal Purposes	School	____________________

INFORMATION TO BE RELEASED OR ACCESSED:

× History & Physical	Consultation Report	Emergency Room Record
× Operative Reports	Discharge/Death Summary	× Face Sheet
× Lab/Path Reports	× X-Ray Reports/Images	Other: _______________

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

Dr. Christi Menges (636) 484-5270

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

15838 Fountain Plaza Dr Chesterfield, MO 63017 Fax number (636)344-2008

Address (Street, City, State and ZIP)

FROM:

St. Louis Women's Healthcare Group (636) 449-4700

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

16216 Baxter Rd Suite 100 Chesterfield, MO 63017

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

I understand that under Missouri law, I have the right to access or to get a copy of my medical record within a reasonable amount of time (usually 30 days) after my request is received.

Date: ________________ Signature: ____

Patient or Legally Authorized Representative

____

Printed Name of Patient or Legally Authorized Representative

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Relationship to Patient

Print or Screenshot and print and return to jbaker@stlobgyn.com