BJC Medical Group

Authorization for Release of Information

I hereby authorize/request _____ to release medical information of:
(Provider Name)

Patient Name: _____

Former Name(s) (where applicable): _____

Date of Birth:_____Social Security Number:_____

I request only the following information to be released:

- □ All Records
- □ Progress/Office Visit Notes
- □ X-Ray/Imaging Reports
- □ Diagnostic Test Results
- □ Pathology Reports
- □ Laboratory (specify)_____
- □ Other (specify)_____
- □ Medication List
- □ Procedures
- □ Immunization/Vaccine Summary
- □ EKG
- □ Itemized Billing Statement

Date(s) of Treatment:_____

Release or Mail To: _____
(Individual/Physician/institution/Agency)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(Telephone Number)

For the purpose of:_____

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither BJC HealthCare nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire ninety (90) days from the date it is signed if I do not cancel