it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax or bring the letter to the address or fax number noted at the bottom of this page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative.

If this Authorization is being presented pursuant to litigation, complete this section.
If this Authorization is being completed pursuant to litigation, please note that this Authorization includes medical records, reports and other medical documents in your possession which relate to any prior or subsequent complaints, injuries, illnesses, or other conditions involving the same parts of the body and the same or similar conditions as described below. This Authorization includes but is not limited to records of all examinations, treatments and tests, including inpatient, outpatient and emergency room, whether for diagnostic or prognostic purposes, consultation reports, correspondence, x-rays, photographs, videotapes, MRIs and CT scans and post-mortem records, if applicable, **PROVIDED** that the examinations, treatments and/or tests involve or relate to complaints, injuries, illnesses 01' conditions pertaining to the following alleged injury:

_____
[insert allegation from petition which describes injured part(s) of body]

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above-referenced care. The decision to enter into any such conversation is that of the health care provider. However, disclosure that exceeds the scope of this authorization may subject the health care provider to civil liability.

This authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required.

[The patient further requests that the health care provider supply complete copies of all documents produced pursuant to this authorization to patient's attorneys,_____, at their expense.
(If desired by Plaintiff's counsel)]

NOTE: Records will be mailed to above address unless otherwise noted below.

_____ _____
Signature of Patient/Legal Guardian/Personal Representative Date

_____ _____
If someone else signs on behalf of the patient, state your relationship to the patient. Date

_____ _____
Witness Date

NOTE:
If above address is not patient's, please complete the following:

Patient Address: _____

BJC Medical Group ATTN: HIM
670 Mason Ridge Center Drive
St. Louis, MO 63141
(P) 314-996-7626 (F) 314-996-7658