3PHealthSTL.com
Phone & Text: 314-744-9398
Email: DrSanders@3PHealthSTL.com

Authorization to Release Records

Patient Name:_____

Address:_____

Phone #:_____ DOB:_____

Where to Send Requested Information

Provider Name:_____

Provider Address:_____

Phone #:_____ Email:_____

____Patient Intake Form ____Patient Imaging ____Patient Lab Testing Results

____Patient Chart Notes from the following dates:_____

____Additional Information:_____

Send Information by ____Secure Email ____Mail

I, (name)_____, do hereby authorize 3 Pillars Health, LLC to release the indicated information to the party named above. I understand that this information is my private health information known as my personal medical records and give my written permission to share it with the intended party.

I acknowledge that 3 PIllars Heath, LLC is no longer an operational business and may require up to 30 days to produce the requested information.

Signature:_____ Date:_____