Authorization for Release of Protected Health Information

Patient Name: ____
Last First MI Maiden

Date of Birth: ______-______-______ Address: ____ City: ____________________
MO DAY YR

State: _____________ Zip: _____________ Home Phone: _________________ Other Phone: _________________

I hereby authorize: ______________________________ (insert provider information below) **to disclose my protected health information to St. Anthony's VASCULAR SURGEONS Office at 10012 Kennerly Road, Suite 305, St. Louis, MO 63128:**

Name: ____________________________________
Address: __________________________________
City/State/Zip:_____________________________
Phone: _________________ Fax: _______________

St. Anthony's
VASCULAR SURGEONS Office
10012 Kennerly Road, Suite 305
St. Louis, Missouri 63128
Phone: 314-525-4325 Fax: 314-525-4365

☐ Mail ☐ Hold for pick up by: ____________________

INFORMATION TO BE RELEASED:

	DATES
☐ ALL MEDICAL RECORDS	____________
☐ DISCHARGE SUMMARY	____________
☐ HISTORY & PHYSICAL EXAM	____________
☐ PROGRESS NOTES	____________
☐ LAB REPORTS	____________
☐ X-RAY REPORTS	____________
☐ MEDICATION RECORDS	____________
☐ DETAILED BILL, STATEMENT	____________

I understand that certain records may be protected by Federal or State law including the records listed below. Therefore, I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)

☐ Mental health or behavioral health

☐ HIV related information (AIDS related testing)

X____
Signature of patient or legal representative Date

☐ DIAGNOSTIC TEST RESULTS (SPECIFY TEST)__________________ ☐ OTHER: ____

PURPOSE OF DISCLOSURE:

☐ Changing Physicians ☐ Consultation ☐ Insurance/Workers Compensation ☐ School ☐ Research

☐ Legal (Specify):____

☐ Other (Specify):____

☐ For personal access (specify): ☐ Copy ☐ Inspection ☐ Summary

ACKNOWLEDGEMENT OF UNDERSTANDING: Initial each line

______I understand the expiration date of the authorization is ☐________________ ☐ at the end of the research study ☐ not applicable for on going research.

______I understand that I may revoke this authorization at any time by notifying Heart Specialty Associates in writing at 10012 Kennerly Road, Suite 300, St. Louis, Missouri 63128 but that if I revoke this authorization it will have no effect on action already taken in reliance on this form.

______I understand that if the person or entity that receives the described information pursuant to this authorization is not a health care provider or health plan covered by Federal privacy regulations, that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations.

______Heart Specialty Associates will not condition treatment or payment on whether you sign the authorization except in certain circumstances related to research.

______I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.

______I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and I have the right to request review of any denial of access other than those made in accordance with applicable law.

______I understand that I may be required to pay the cost of preparing and mailing copies, supervising inspection of my records, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.

Signature: ____ Date: ______Relationship/Authority to Act________________
Patient or Legal representative

Records Received By: ________________________________ Date:______________ ID Verified:____________________