ST. Anthony's
HEART SPECIALTY ASSOCIATES

Authorization for Release of Protected Health Information from HSA

Patient Name:

_____
Last First MI Maiden

Date of Birth: ____-_____-____ Address: _____ City: _____
MO DAY YR

State: _____ Zip: _____ Home Phone: _____ Other Phone: _____

I hereby authorize: THE ST. ANTHONY'S HEART SPECIALTY ASSOCIATES Mark one office location:

- ☐ **SOUTH COUNTY OFFICE** (Physician Office Center, 10012 Kennerly Road, Suite 300, St. Louis, MO 63128)
- ☐ **KIRKWOOD OFFICE** (1001 S. Kirkwood Rd., Suite 310, St. Louis, MO 63122)
- ☐ **SHREWSBURY OFFICE** (7345 Watson Rd., Lower Level 1, St. Louis, MO 63119)
- ☐ **ELECTROPHYSIOLOGY OFFICE** (Physician office Center, 10012 Kennerly Road, Suite 202, St. Louis, MO 63128)

To disclose my protected health information as indicated below to the party listed below:

Name:_____
Address:_____
City/State/Zip:_____
Phone: _____ Fax: _____

☐ 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 _____
- ☐ DIAGNOSTIC TEST RESULTS (SPECIFY TEST) _____ ☐
OTHER:_____

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

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 ongoing research.

____I understand that I may revoke this authorization at any time by notifying Heart Specialty Associates in writing but 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: _____