ST. Anthony's
HEART SPECIALTY ASSOCIATES

Authorization for Release of Protected Health Information to HSA

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 The Heart Specialty Associates** Mark one office location:

☐ **SOUTH COUNTY OFFICE** (Physician Office Center, 10012 Kennerly Road, Suite 300, St. Louis, MO 63128, Phn: 314-842-0602, Fax: 314-842-4372)

☐ **KIRKWOOD OFFICE** (1001 S. Kirkwood Rd., Suite 310, St. Louis, MO 63122, PHN: 314-842-0602, Fax: 314-842-4372)

☐ **SHREWSBURY OFFICE** (7345 Watson Rd., Lower Level 1, St. Louis, MO 63119, PHN: 314-842-0602, Fax 314-842-4372)

☐ **ELECTROPHYSIOLOGY OFFICE** (Physician office Center, 10012 Kennerly Rd, Suite 202, St. Louis, MO 63128, Phn: 314-692-2807,Fax: 314-991-0727)

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

Name:____

Address:____

City/State/Zip:_______________________________________

Phone: __________________ Fax: _______________________

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 ongoing 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: ______________________________