Medical Records Release Authorization

Authorization for Use and Disclosure of Protected Health Information (PHI)

_____ _____
Patient's Full Legal Name Patient's Date of Birth

_____ (_____) _____ (_____) _____
Patient's Social Security Number Patient's Telephone Number Patient's Alternate Telephone Number

_____
Street Address Apt. No. City State Zip Code

Information to be Released (check all that apply)

- ❒ Financial statement
- ❒ Complete health/medical information

Purpose of Disclosure (check all that apply)

- ❒ Changing Physicians
- ❒ Consultation or second opinion
- ❒ Continuing care
- ❒ Legal
- ❒ School
- ❒ Insurance
- ❒ Worker's Comp
- ❒ Other, specify: _____

Date(s) of Service: _____

- **Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release**: I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to release.
- **Time Limit & Right to Revoke Authorization**: Unless revoked, this authorization will expire one (1) year from the date of this execution, unless otherwise specified. A Photostat copy of this authorization shall be considered as effective and valid as the original. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving revocation.
- **Re-disclosure**: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Probability and Accountability Act of 1996. The facility, its employees, officers, physicians are hereby released from any legal responsibility or liability for disclosure of the above information for the extent indicated and authorized therein.
- Furthermore, I understand that my health care provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

Based on Section 191.227 HB 351 of the Missouri Department of Health and Senior Services Regulations, St. Louis Eye Surgery and Laser Center, may assess a maximum fee for copying of $25.34 plus $0.58 per page for the cost of labor and supplies for copies provided in paper form and $23.72 for additional costs if records are maintained off-site. For copies provided in digital format, the maximum fee for copying will be $25.34 plus $0.58 per page, or $111.03 total, whichever is less. (effective fee date 02/01/2019).

_____
Printed Name of Patient

_____ _____
Signature of Patient or Legal Guardian Today's Date