AUTHORIZATION for DISCLOSURE

SLU*Care*

The Physicians of Saint Louis University

Health Information Management
Correspondence Division
West Pavilion, Ground Floor
3655 Vista Ave
St Louis, MO 63110
314-268-7012

I authorize Saint Louis University/SLU*Care* to release the following information

Patient's Name / Previous Names:

____

____
Birth Date   Social Security Number   Medical Record #

RECIPIENT (person or organization that will receive your information)

Hoosier Services Inc.
(Doctor / Hospital / Attorney / Insurance Company / Self / etc.)

18032 Lemon Dr.,#C-618, Yorba Linda, CA 92886   800-882-4156
Address (Street, City, State, ZIP code)   Phone Number

DESCRIPTION of INFORMATION to be RELEASED

Check items that apply:

☐ Psychotherapy notes   **<u>If you check this box, you may not check another box below.</u>**
Federal law requires a separate authorization to use or release psychotherapy notes.

☐ All SLU*Care* Records

☐ All Records (*including outside provider records*)

Specific Information Only *(May list specific incident or identify body region)*

- ☐ Summary of Medical History/Treatment
- ☐ Laboratory / Diagnostic Tests
- ☐ Immunization Records
- ☐ Pathology Reports(s) (SLU*Care*)
- ☐ Radiology Reports
- ☐ Operative Report (SLU*Care*)
- ☐ Progress Note
- ☐ Psychological Testing
- ☐ After Visit Summary
- ☐ EKG Report
- ☐ EEG Report
- ☐ Genetic Testing
- ☐ Billing Information
- ☐ Other________________________

____

Outpatient, Date(s) of Service: ____

Records from Specific Provider(s) ____

Body Region / Incident ____

Note: This authorization does not allow release of radiology films, pathology slides.

PURPOSE of DISCLOSURE

- ☐ Continuing Medical Care
- ☐ Social Security/Disability
- ☐ School
- ☐ Military
- ☐ Other (specify) ______Life Insurance______
- ☐ Legal Purposes
- ☐ Insurance
- ☐ Patient's Request

I understand that the specific information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including human immunodeficiency virus, (HIV) and acquired immune deficiency syndrome (AIDS), or specific information which requires release by a minor. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice.

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that fees may be associated with this request for medical information.

EXPIRATION (Dates of service after signature date will not be released)

This authorization expires on the following date, event, or special condition.

____

(*If no expiration is provided, this authorization will expire in one year.)*

APPROVAL (You or your Personal Representative must sign and date this form for completion.)

Patient:

____
(Print Name)

____
(Signature)

____
(Date)

Patient Representative: The person who has legal authority to act on behalf of the individual. A copy of a Healthcare Power of Attorney or other legal document must be on file or submitted with this form.

____
(Printed Name of Personal Representative)

____
(Signature of Personal Representative)

____________ ______________________________
(Date) (Description of Authority)

NOTICE OF REVOCATION

I _________________________________, hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Patient ______________________________________ Date __________________

Personal Representative _____________________________________ Date ________________