ST.LOUIS CANCER CARE, L.P.P

Authorization for Release of Healthcare Information

Please fill out the starred areas only. This is to request records from other Providers.

*Patient Name: MRN:

*Social Security Number: *DOB:

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
Name:_____
Address:_____
3. The type and amount of information to be used or disclosed is as follow:
__Complete Medical Record __ List of Allergies __ Radiology Reports
__Physician Progress Note __ Problem List __EKG's
__Immunization Record __Lab Reports __Medication List
__Other (please specify)_____
Dates of Treatment:_____
4. Unless otherwise provided by law, records and information concerning the following types of diagnoses, care and treatment will be released only if I indicate my specific consent by checking the appropriate box:
__Alcohol Abuse __ Mental Health Notes __Drug and Substance Abuse
__Testing for presence of HIV-Antibodies and /or treatment of AIDS
5. This information may be released to an used by the individual or organization:
Name:_____
Address:_____
For the purpose of:_____
6. I understand that I have the right to cancel this authoriaztion at any time. I understand that if I wish to withdraw this authorization I must do so in writing. I must present my written cancellation to the health information management department. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
7. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I don't have to sign this form to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager. I understand that there may be charge for costs associated with copying my health information.

_____ _____

*Signature of Patient / Legal Representative (specify Relationship to Patient) Date