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 ❒ School

❒ Consultation or second opinion ❒ Insurance

❒ Continuing care ❒ Worker's Comp

❒ Legal ❒ 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, RSMo of the Missouri Department of Health and Senior Services Regulations, St. Louis Eye Surgery and Laser Center may assess a maximum fee for copying medical records of $28.70 plus $.66 per page for the cost of supplies and labor for copies provided in paper form and a retrieval fee not to exceed $26.87. For copies provided electronically, the maximum fees for copying medical records will be $28.70 plus $0.66 per page for the cost of supplies and labor, or a total of $125.78, whichever is less. (Effective fee date 2/1/2024)

_____

Printed Name of Patient

_____ _____

Signature of Patient or Legal Guardian | Today's Date

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