STL VISION
vision for life®

Authorization to Receive/Release Health Information

Patient Name _____ Date of Birth _____ SS# _____
Address _____ City _____ State _____ Zip _____

Records to be released *from*:
Name _____
Address _____
_____

Records to be released *to*:
Name _____
Address _____
_____

Please Release:
_____ Complete Medical Record
_____ Medical Records for Dates of Service From _____ to _____
_____ Other _____

This authorization shall be in effect until the information has been forwarded as requested.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing.

_____ _____ _____
Printed Name of Patient or Representative | Signature of Patient or Representative | Date

6680 Chippewa, Suite 220 St. Louis, MO 63109 phone: 314-351-0101 fax: 314-351-4697