St. Charles Surgery Center

Medical Records Release Authorization

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

_____ _____
Patient's Full 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)

- ☐ Compete health/medical information
- ☐ Financial Statement

Purpose of Disclosure (check all that apply)

- ☐ Changing Physicians
- ☐ Consultation of 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 (1) year from the date of this execution, unless otherwise specified. A Photostat copy of this authorization shall be considered an 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 facilities, 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 of Missouri Department of Health And Senior Services Regulations, St Charles Surgery Center, assess a fee of $20 plus $0.47 per page for supply and labor costs.

Printed Name of Patient

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