Please fill out and fax this form to **844.868.1437**.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:____
Last First MI Maiden

D.O.B.:__________________ S.S.#:___________________ M.R.N.:______________________

I Authorize and Request: BJC Medical Group of Missouri

To Release to: ____

____

____
Name and Address of Individual/Agency

Medical Records covering the periods of health care from_______________ to ______________________
Date Date

from_______________ to ______________________
Date Date

Information to be released*: (NOTE: The patient must check and initial if the following information is to be released*.)

- ❑ OB/GYN Records
- ❑ HIV Testing/Treatment
- ❑ Substance Use/Abuse History
- ❑ Psychiatric Evaluation
- ❑ Other (Please Specify) ____________________________________

The medical record information is needed for: ____

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential."

I understand that neither BJC HealthCare nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I so requested.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax, or bring the letter to the address or fax number at the top of the page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate.

____ ___________________________ ______________
Signature of Patient (If the patient is incompetent, of his guardian or other person authorized under State Law to act in his behalf, if the patient is deceased, of his personal representative or, if none, of his child, parent, sibling) | Relationship to Patient | Date

____ ______________
Signature of Witness | Date