St Louis SURGICAL CONSULTANTS

# REQUEST FOR MEDICAL RECORDS

Patient's Full Name *at Time of Treatment*: ______________________________

Date of Birth: ____ / ____ / ______ Phone Number: ______ - ______ - __________

Patient Address: ______________________________

City: ______________________ State: _______ Zip Code: _____________

*Purpose of Release*: ______________________________

**I hereby authorize St. Louis Surgical Consultants to…**

☐ **Receive my records from…** ☐ **Release my records to…**

*Please fax requested records to* ***314-434-7485***

*St. Louis Surgical Consultants - Attention: Medical Records Requested - Dr.* _________________

Practice/Doctor's Name: ______________________________

Address: ______________________________

City: ______________________ State: _______ Zip Code: _____________

Phone Number: _____ - _____ - ________ **Fax Number**: _____ - _____ - ________

☐ **Fax** *(to health provider or health plan only)* ☐ **Mail Record** (*possible fee*) ☐ **I will pick Up**

| Documents Requested |
| --- |
| *Office Visits, Lab Reports, Operative Notes, Pathology Repots, Radiology Reports* |
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- I understand that if my records contain documentation of **alcohol abuse, psychiatric condition, drug abuse, or communicable diseases**, this information will be released as part of my record.
- I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
- I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. *Note: Request must be in writing and forwarded to management*.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect me ability to obtain treatment.
- I understand that there may be a $15.00 charge for obtaining the requested information.
- I understand that this authorization will expire in 90-days unless an earlier date is specified here _______________.

**Patient Signature**: ______________________________ Date: ____ / _____ / ________

*Please give a copy to the signing individual*