St. Louis Hills Internal Medicine
6901 Chippewa Street
Saint Louis, MO 63109
Phone: (314) 644-7000
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Patrick H. Durbin, MD
April Brumley, FNP-C

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ Social Security #: _____

I. I hereby request and authorize _____ to release, use, and/or disclose the protected health information described below of the patient named above to:

PATRICK H. DURBIN, MD
6901 CHIPPEWA ST.
ST. LOUIS, MO 63109

II. Authorization for Release of Information. Covering the period of health care from:

☐ _____ to _____ **OR** ☐ All past, present and future periods:

a. ☐ I hereby **authorize the release of my complete health record** (including records relating to the mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

b. ☐ I hereby **authorize the release of my complete health record with the exception of the following information:**

☐ Mental health records

☐ Alcohol/drug abuse treatment

☐ Communicable diseases (including HIV and AIDS)

☐ Other: _____

III. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

IV. This authorization shall be in force and effect for ninety days after the signature date at which time this authorization expires.

V. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

VI. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

VII. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____ _____
PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT