St. Louis Hills Internal Medicine
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Saint Louis, MO 63109
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Patrick H. Durbin, MD
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HIPAA Authorization to Disclose Protected Health Information

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I understand that it is my responsibility to provide authorization to St. Louis Hills Internal Medicine in order to release health information. I hereby authorize release of information regarding my health care to:

NAME	ADDRESS	PHONE	RELATIONSHIP

By signing this consent form, you are authorizing St. Louis Hills Internal Medicine to provide verbal or written information regarding my medical condition to the above named person(s).

I have had the chance to ask questions regarding this authorization and all of my questions have been answered to my satisfaction.

Patient Date