AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO: _____
(*Physician, Individual or Agency*)

_____
(*address*)

_____

FROM: KIRKWOOD FAMILY/INTERNAL MEDICINE
10296 Big Bend Blvd., Suite 111
St. Louis, MO 63122
314-543-5943-phone
314-543-5953-fax

I hereby request and authorize you to release the following records (please check all that apply):

☐ All medical records concerning my care and treatment rendered by you, except those relating to: _____ (fill in, if applicable).

Dates of Service _____ to _____

PATIENT NAME _____
(*Please print*)

_____ (*Date of birth*)

_____ (*Social security number*)

Important: I understand that unless I specifically request that such information not be disclosed, authorized disclosure may contain Protected Health Information containing diagnosis, treatment and other information regarding psychiatric and mental health, substance abuse (chemical dependency), HIV and/or AIDS.

The Protected Health Information indicated above is to be used and/or disclosed for the following purpose(s):

_____ continuity of care _____reimbursement _____other:_____
(*specify*)

To be read by patient prior to signing:

- I understand that I may refuse to sign this authorization.
- I understand that my treatment by Kirkwood Family Medicine or payment for that treatment will not be affected if I do not sign this form.
- I understand that I may request to inspect and copy the Protected Health Information that is to be used and/or disclosed pursuant to this authorization.
- I understand that I should receive a copy of this authorization form after I sign it.
- I understand that if I authorize release of my Protected Health Information to a person or organization that is not subject to federal law governing privacy and that person or organization redisclosures my Protected Health Information, my Protected Health Information may no longer be protected by federal privacy laws.
- I understand I may revoke this authorization at any time by notifying Kirkwood Family/Internal Medicine in writing, at the above address, but that any such revocation will not have any effect on any actions that Kirkwood Family Medicine took before receiving the revocation.
- This authorization expires on _____ or 90 days of the date signed if I have not provided an expiration date or an expiration event.
  (*Date or Event*)

A photo static copy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Patient or Patient's Representative Date

*If signed by patient's representative, indicate relationship to the patient _____

Telephone number where patient may be contacted _____