St. Louis Pediatric Associates, Inc.

AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIED HEALTH INFORMATION

If any sections are incomplete, this form may be invalid

PATIENT INFORMATION:

Name: _____ Birth Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

RELEASE INFORMATION FROM:

St Louis Pediatric Associates
226 S Woods Mill Rd 32W Chesterfield MO 63017
Phone (314)-576-1616 Fax (314)-576-4838

Other
Name: _____

Address:_____

City:_____State:_____Zip: _____

Phone:_____ Fax: _____

RELEASE INFORMATION TO:

St Louis Pediatric Associates
226 S Woods Mill Rd 32W Chesterfield MO 63017
Phone (314)-576-1616 Fax (314)-576-4838

Other
Name: _____

Address:_____

City:_____State:_____Zip: _____

Phone:_____ Fax: _____

PURPOSE FOR THE RELEASE OF INFORMATION:

□ Transferring to Adult Practice □ Visit to a specialist
□ Attorney Use □ Personal Use
□ Transferring to another Pediatric Practice
□ Other (describe): _____

There is a fee (base plus per page) for SLPA to copy and send records. This fee is waived if sending directly to another physician's office. This fee is determined by the state each year. Please call our medical records department to get the current fee schedule.

DESCRIPTION OF INFORMATION BEING RELEASED:

Specific date(s) of service (required; list all dates):

From _____ To _____

I would like (choose one):
□ An abstract (pertinent information related to the above listed date(s))
□ Complete Health Record
□ Billing Records
□Other:_____

SENSITIVE INFORMATION RELEASE: I understand if my medical record or billing record contains information that references drug/ alcohol abuse, psychiatric care, mental health treatment, HIV/AIDS, I agree to its release.

I hereby authorize St. Louis Pediatric Associates, Inc. (SLPA) to use or disclose protected health information regarding my child's care and treatment. I understand that information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV- related information, the recipient is prohibited from re-disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who receive or use my HIV- related information without authorization.

I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed below, except to the extent SLPA has already relied upon this authorization. **S**igning this authorization is voluntary. SLPA may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms of this document. If you do not agree with any part of this document, you may speak to the privacy officer.

- **If the patient is 18 years of age or older,** the patient must sign and date the form
- **If the patient is 18 years of age or older and is incapable of signing,** a substitute who is legally authorized may sign and date the form. You must indicate your legal authority after your signature.
- **If the patient is 17 years of age or younger,** a parent or legal guardian must sign and date the form, unless there is an exception under state or federal law.

□ Self □ Other_____
Signature: _____ □ Parent □ Guardian **Date:** _____/_____/_____

Unless revoked, this Authorization will expire 90 days from date of signature, unless otherwise specified.