



# AUTHORIZATION FOR RELEASE OF INFORMATION OR INDIVIDUAL ACCESS TO INFORMATION

3015 N. Ballas Road • St. Louis, Missouri 63131  
314-996-5000

I hereby authorize Missouri Baptist Medical Center to:  release or grant me access to medical information of:

\_\_\_\_\_ (Patient's Full Name)

Former Names (where applicable): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I request **only** the following information to be released/obtained:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Designated Record Set | <input type="checkbox"/> Pathology Report      | <input type="checkbox"/> Cardiac Cath Lab Cine Film | <input type="checkbox"/> West County Sports Fitness |
| <input type="checkbox"/> Abstract              | <input type="checkbox"/> Laboratory (specify): | <input type="checkbox"/> Cardiac Cath Lab Reports   | <input type="checkbox"/> Womens Wellness Ultrasound |
| <input type="checkbox"/> Emergency Report      | <input type="checkbox"/> X-Ray Reports         | <input type="checkbox"/> EKG                        | <input type="checkbox"/> Breast Healthcare Center   |
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> X-Ray Films           | <input type="checkbox"/> Cancer Center              | <input type="checkbox"/> Itemized Billing Statement |
| <input type="checkbox"/> History and Physical  | <input type="checkbox"/> Mammograms            | <input type="checkbox"/> Radiation Oncology         | <input type="checkbox"/> Other (specify): _____     |
| <input type="checkbox"/> Operative Report      |  |   |   |

Date(s) of Treatment: \_\_\_\_\_

Release or Mail to: Individual / Physician / Institution / Agency: \_\_\_\_\_

(circle one) Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

For the purpose of: \_\_\_\_\_  
(for patient request state "self")

**ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.**

I understand that neither BJC HealthCare nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax or bring the letter to the address or fax number noted at the top of this page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate if the patient did not expire in the facility the information is being requested from.

**IF THIS AUTHORIZATION IS BEING PRESENTED  
PURSUANT TO LITIGATION, COMPLETE THIS SECTION.**

If this Authorization is being completed pursuant to litigation, please note that this Authorization includes medical records, reports and other medical documents in your possession which relate to any prior or subsequent complaints, injuries, illnesses, or other conditions involving the same parts of the body and the same or similar conditions as described below. This Authorization includes but is not limited to records of all examinations, treatments and tests, including inpatient, outpatient and emergency room, whether for diagnostic or prognostic purposes, consultation reports, correspondence, x-rays, photographs, videotapes, MRI's and CT scans and post-mortem records, if applicable, **PROVIDED** that the examinations, treatments and/or tests involve or relate to complaints, injuries, illnesses or conditions pertaining to the following alleged injury:

**[insert allegation from petition which describes injured part(s) of body]**

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above-referenced care. The decision to enter into any such conversation is that of the health care provider. However, disclosure that exceeds the scope of this authorization may subject the health care provider to civil liability.

This Authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required.

*[The patient further requests that the health care provider supply complete copies of all documents produced pursuant to this authorization to patient's attorneys, \_\_\_\_\_, at their expense. (If desired by Plaintiff's counsel)].*

**NOTE: Records will be mailed to above address unless otherwise noted below.**

\_\_\_\_\_  
**Signature of Patient/Legal Guardian/Personal Representative** **Date**

\_\_\_\_\_  
**If someone else signs on behalf of the patient, state your relationship to the patient** **Date**

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NOTE: If above address is not the patient's, please complete the following:**

**Patient Address:** \_\_\_\_\_

**Check if Patient will pick up copies at Missouri Baptist Medical Center:**

**Facility Use Only:** *Date Access/Request Granted:* \_\_\_\_\_  
*Other Disposition (Date/Action):* \_\_\_\_\_