AFFINIA HEALTHCARE

AUTHORIZATION FOR THE RELEASE OF
PROTECTED HEALTH INFORMATION

Name of Patient :		Patient's Maiden Name:	
Relationship to patient:			
Date of Birth	Social Security Number		
Street Address	City	State	Zip
Medical Record Number			

I request access to the protected health information below from (date) _____to (date) _____

D/S Summary	Physical Form	Radiology Reports
H&P	Prenatal Records	Lab Reports
Progress Notes	Psychotherapy Notes	Other _____
Immunizations	Operative Notes	_____

Please state the reason for the request:_____

I hereby authorize Affinia Healthcare to obtain/send:

Records From:	Records To:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Indicate the appropriate Affinia Healthcare facility/facilities:

Affinia @ 1717 Biddle St. St. Louis, MO 63106	Affinia @ 3930 S. Broadway St. Louis, MO 63118	Affinia @ 2220 Lemp Ave. St. Louis, MO 63104	Affinia @ 4414 N. Florissant St. Louis, MO 63107

Telephone - (314) 814-8563 or (314) 814-8711
Fax - (314) 814-8589 or (314) 814-8678

I understand that my medical records or the medical record of the patient for whom I am signing may include Alcohol Abuse, Psychiatric Treatment records, or HIV/AIDS Testing and Treatment and are covered by federal regulations and are protected under these regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that prior action has been taken on it. In any even this consent will expire on _____ or no longer than (1) year from the date the authorization is signed. Affinia Healthcare is hereby released from all legal liability or responsibility for the release of records to the extent indicated and authorized herein. Affinia Healthcare may not condition my treatment on my provision of this authorization. A Photocopy or fax of this authorization is as valid as the original.

I understand that once the information is disclosed pursuant to this authorization, the recipient may re-disclose it and the information may not be protected by federal regulations.

Signature_____ Date_____

(Signature of patient) If the patient is incompetent, of his guardian or other person authorized under State Law to act in his behalf, if the patient is deceased, of his personal representative, or if none, of his spouse, if none, of his child, parent, sibling, etc.

Relationship to Patient_____ Witness Signature:_____

White Copy-Chart **Yellow Copy-Other Facility** **Pink Copy-Patient**