BOONSLICK MEDICAL GROUP, INC.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_______________________________________ (Print **patient's** full name)

_______________________________________ (Street address)

_______________________________________ (City, state, zip code)

____________________________ Birth date (Mo/Day/Yr)

____________________________ Social Security Number

____________________________ Phone (Home)

At the request of the individual, I ____________________ (patient's name), do hereby authorize _____________ (site name) to release:

______DISCHARGE SUMMARY
______HISTORY & PHYSICAL
______PROGRESS NOTES
______ECG/EEG/CARDIC CATH
_______PATHOLOGY REPORTS
_______LABORATORY REPORTS
_______RADIOLOGY REPORTS
_______OPERATIVE REPORTS
________EMERGENCY REPORTS
_______OTHER______________________________
____

from________________________ to _________________________.

_____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: ____
Name of Company/Agency/Facility/Person

____
Street address

____
City, state, zip

PURPOSE OF DISCLOSURE:

______INSURANCE
______LEGAL INVESTIGATION
______WORKERS COMP
______DISABILITY DETERMINATION
______CHANGE OF DOCTOR
_______PERSONAL

OTHER (SPECIFY)____

Please provide DAYTIME telephone number in the event we need to contact you: ___________________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

____
Signature of individual (or guardian or Personal Representative of patient's estate)

____
Date