Associates in Women's Health Care, LLC

Mary T. Grimm, MD Sharon S. Sung, MD Angela M. Taylor, WHNP

Patient Name: _____ Date of Birth: _____

Last 4 Digits of Social Security Number: __ __ __ __ Date of Visit: _____

Purpose of Request: _____

I hereby authorize _____

To Release To:	To Obtain From:
Organization:	Organization:
Address:	Address:

I specifically authorize the use and disclosure of the following:

☐ Complete Medical Record(s) **OR** ☐ Discharge Summary ☐ Progress Notes

☐ History & Physical Examination ☐ Laboratory Results

☐ Consultation Reports ☐ Radiology Reports

☐ Photographs, Video Tapes, Digital or Other Images

☐ Other (please specify): _____

The information to be used or disclosed pursuant to this authorization may include information relating to: (1) AIDS or HIV Infection; (2) treatment of drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care.

Please DO NOT RELEASE any information that has been checked below, if it appears in the record.

☐ Alcohol Abuse ☐ Drug Abuse

☐ Psychological / Psychiatric conditions ☐ AIDS / HIV results

I may revoke this authorization in writing at any time. I understand that such revocation will not have any effect on the information already used or disclosed before receipt of my written notice of revocation. Unless earlier revoked, this authorization will expire one year from the date it was signed. I understand I may choose to restrict or extend the expiration date. I may request to inspect or copy the information to be disclosed. I may refuse to sign this authorization. I understand that I am not required to sign the authorization to receive treatment. Once release of this information is made to the above named person/ organization, my information may be subject to re-disclosure by the recipient.

I may be charged fees for the copying of such information if I am requesting information for myself or for a third party. Such fees will comply with state and federal laws.

I have read the above information and authorize disclosure of the identified information to the person/organization and for the purpose described herein. I understand that, by signing this document, I release and discharge the disclosing entity from any liability and will hold it harmless for any release made pursuant to the authorization.

Signature: _____ Date _____ Time: _____

Relationship to patient: _____ Authorization Expires: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

226. S. Woods Mill Road, Suite 60 West
Chesterfield, MO 63017
Office: (314) 878-7333 Fax: (314) 878-7453