

MIDWEST MATERNAL FETAL MEDICINE
Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____
 Address: _____

Date of Birth: _____
 SSN: _____
 Telephone: _____

Information to be released – covering the periods of health care:

From (date): _____ To (date): _____

Please check type of information to be released:

<input type="checkbox"/> Treatment or consultation	<input type="checkbox"/> Diagnosis & treatment codes	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> History & physical exam	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> X-ray reports	<input type="checkbox"/> X-ray films/images
<input type="checkbox"/> Photographs, videotapes	<input type="checkbox"/> Complete billing record	<input type="checkbox"/> Itemized bill
<input type="checkbox"/> Other (specify)		

Purpose of Request:

<input type="checkbox"/> Treatment or consultation	<input type="checkbox"/> At the request of the patient
<input type="checkbox"/> Other (specify)	

Who and Where to Send/Release Information:

Midwest Maternal Fetal Medicine
 621 South New Ballas, Suite 2007B
 St. Louis, MO 63141
 314-991-5000 (ph) 314-991-5035 (fax)

James Bartelsmeyer, M.D.
 Sue Moore, M.D.
 Bruce Morris, M.D.
 Gilbert Webb, M.D.

Drug and/or Alcohol Abuse, and/or Psychiatric and/or HIV/AIDS Records Release:

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. Yes No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. Yes No

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time you have the right to revoke this authorization by submitting a notice in writing to Midwest Maternal Fetal Medicine to whom you are authorizing disclosure. Unless revoked, this authorization will expire on the following date or event _____, or 90 days from the date of signature, unless otherwise specified.

Re-Disclosure:

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure:

I understand that I do not have to sign this authorization for Midwest Maternal Fetal Medicine to disclose information for the purposes of treatment, payment or operations. I can inspect or copy the protected health information to be used or disclosed. I authorize Midwest Maternal Fetal Medicine to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if Not Patient: _____ Witness: _____

Identity of Requestor Verified Via: Photo Matching Signature Other (specify): _____

ID Verified By: _____ Date: _____