MEDICAL RECORD RELEASE AUTHORIZATION

DOCTOR/HOSP: ______________________________

STREET ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

____

____

____

VIA FAX ____________________

☐ MY COMPLETE HISTORY AND/OR MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING ILLNESS AND/OR TREATMENT EXCLUDING PHOTOGRAPHS OR INCLUDING PHOTOGRAPHS

☐ CT SCAN, MRI, X-RAYS: ______________________________

☐ HEARING TESTS AND TYMPANOGRAMS

☐ SLEEP STUDY AND/OR CPAP RECORDS

☐ OTHER: ______________________________

DURING THE PERIOD FROM ________________ TO ________________.

PATIENT: ______________________________

DATE OF BIRTH: ____________SOCIAL SECURITY #____________________

STREET ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

I hereby authorize the use or disclosure of my individually identifiable health information as described above.

I understand this authorization is voluntary.

I understand that my health care, payment for my health care, or enrollment or eligibility for benefits will not be affected if I do not sign this form.

I understand that the information released here may no longer be protected by federal privacy regulations and may be subject to re-disclosure.

I understand that I have the right to revoke this authorization at any time by notifying Robert D. Craig, M.D., Inc. in writing at 777 South New Ballas, Suite 320E, St. Louis, MO 63141. I understand that the revocation will not apply to information that has already been released in response to this authorization.

SIGNATURE: ______________________________

IF GUARDIAN, STATE RELATIONSHIP ______________________________

DATE: ________________

WITNESS: ______________________________

REVOCATION OF AUTHORIZATION

I hereby revoke an Authorization for Use and Disclosure of Health Information signed (date)_______________ effective immediately.

From: Robert D. Craig, M.D.
777 South New Ballas Road
Suite 320E
St. Louis, MO 63141

To: ______________________________
____
____
____

VIA FAX ______________________

☐ MY COMPLETE HISTORY AND/OR MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING ILLNESS AND/OR TREATMENT EXCLUDING PHOTOGRAPHS OR INCLUDING PHOTOGRAPHS
☐ CT SCAN, MRI, X-RAYS: ______________________________
☐ HEARING TESTS AND TYMPANOGRAMS
☐ SLEEP STUDY AND/OR CPAP RECORDS
☐ OTHER: ______________________________

DURING THE PERIOD FROM ____________________ TO ____________________.

PATIENT: ______________________________

DATE OF BIRTH: ______________SOCIAL SECURITY #__________________

STREET ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

I understand that the health information may already have been disclosed pursuant to and in reliance on my prior Authorization. I also understand that this revocation applies only to the information specifically described in the above referenced document, and does not affect any prior executed Authorizations for other information.

SIGNATURE: ______________________________

IF GUARDIAN, STATE RELATIONSHIP ______________________________

DATE: ____________________