SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314.344.6800 Phone
314.344.6801 Fax
ssmweightloss.com

Mario Morales, MD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

1. I hereby authorize SSM Weight Loss Institute to:
   ___ obtain from: specify clinic, if applicable ___ release to:

   _____

   (who is to receive the information from SSM Weight Loss Institute or who is to send information to SSM Weight Loss Institute)

   _____

   Address/Phone number of above

   The following information from the medical records of:

   _____

   Patient's Name - PLEASE PRINT Date of Birth Treatment Date(s)

2. Information to be released: (payment of a fee may be required before release of the following information)
   ___ History and Physical Examination
   ___ Discharge Summary
   ___ Laboratory Data
   ___ Physician Notes
   ___ Emergency Room Report
   ___ Face sheet
   ___ Operative Report(s)
   ___ Pathology Report(s)
   ___ Physician's Orders
   ___ Short Stay Form
   ___ Consultation by Dr. _____
   ___ Radiology Report/X-Ray Films (films released only through Radiology
   ___ Nursing Notes
   ___ EKG Cardiology Report
   ___ Clinic Notes for dates: _____
   ___ Other-specify: _____

3. There are no limitations placed on dates, history of illness or diagnostic and therapeutic information, including any treatment of alcohol use/abuse, drug use/abuse, HIV-AIDS, mental health treatment, or psychiatric treatment.

   I agree with the above statement. SIGNER MUST INITIAL THIS CLAUSE:_____

   OR specify information you wish to release:

   _____

4. The above information is released for the following purpose and that purpose only:
   ___ Continuation of Care ___ Legal Purposes ___ Insurance Purposes
   ___ Employer Requirement ___ Personal Reasons
   ___ Other: _____

Continued on back

PATIENT LABEL

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5. Revocation Process: I understand that I may, by placing my request in writing to SSM Weight Loss Institute, revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this authorization will expire three months from the date of my signature or as otherwise specified by date, event or condition as follows.

6. Photocopy: I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that SSM Weight Loss Institute, may deny the release of protected health information, if it has reason to believe this authorization has been altered or is not a true and accurate authorization initiated by the patient or the appropriate legal representative.

_____ _____
Patient's Signature Date
(Photo identification may be required)

_____ _____
Signature of Other Individual Relationship of Other to Patient

_____ _____
Witness Date

REDISCLOSURE: i understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by Federal confidentiality rules. **SIGNER MUST INITIAL THIS CLAUSE:** _____

PROHIBITION OF REDISCLOSURE: Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical information is not sufficient for this purpose.

Information has been released per authorization by _____
on date _____

ALL RECORDS ARE $0.52 PER PAGE

PATIENT LABEL