AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Middle Initial _____ Last Name _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____

I, authorize

Company Name _____

Address _____

City, State, Zip _____

Telephone # _____ Fax # _____

to disclose the following medical information to : Town & Country Pediatrics, PC
3009 N. Ballas, Suite 141A
Town & Country, MO 63131

This authorization extends only to documents *initialed* below:

_____ Record of Visits From _____ To _____

_____ Progress Notes From _____ To _____

_____ Consultation Reports From _____ To _____

_____ History and Physical Examination

_____ Lab Reports Type of Test _____ Date _____

_____ X-Ray Reports Date taken _____

_____ Discharge Summary Date of Discharge _____

_____ History and Physical Examination Date _____

_____ Statement of Charges or Payments From _____ To _____

_____ Mental Health or Illness

_____ Alcohol and/or Chemical Dependency or Treatment

_____ All of the Above (does not include Mental Health, Alcohol and/or Drug Dependency or Treatment, STD Testing or Status or Genetic Testing, unless specifically authorized)

(OVER)

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization.

2. I have the right to inspect or copy the Protected Health Information (PHI) to be used or disclosed.

3. I may revoke this authorization at any time, except where information has already been released, by completing Town & Country Pediatrics, PC's Revocation of an Authorization Form.

4. This authorization is valid for a 1 year period from the date it is signed, if an expiration date is not provided by me below.

5. A photocopy or fax of this Authorization Form is as valid as the original.

6. I understand that information uses or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____	_____
Please Print Name	Date
_____	_____
Signature	Relationship to Patient
_____	_____
Witness	Date
_____	_____
Expiration Date (If other than 1 year from date signed)	Revocation Date