Midwest Hemorrhoid Treatment Center

450 N. New Ballas Rd., Suite 266
Creve Coeur, MO 63141
Ph: 314-991-9888 Fax: 314-991-9886

Authorization for Release of Protected Health Information

PATIENT NAME:	PHONE #:	DATE OF BIRTH:
PATIENT'S ADDRESS:	Requestor's Name/Phone # (if patient is not the requestor):	

Protected Health Information to be released by Midwest Hemorrhoid Treatment Center.

To (PHI Recipient Name):	Address/City/State/Zip	Phone #: Fax #:

This authorization will expire on the following: (Fill in the Date or the Event, but not both)
Date: Event:

Purpose of Disclosure:

Description	Date(s):	Description	Date(s):
☐ All PHI in record		☐ Nursing Notes	
☐ History and Physical		☐ Medication Record	
☐ Consult Report		☐ Demographics	
☐ Operative Report		☐ Rehabilitation Services	
☐ Progress Notes		☐ Special Test/Therapy	
☐ Physician Orders		☐ Itemized Bill/Claims	
☐ Laboratory		☐ Other:	
☐ Imaging/Radiology			

1. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse and psychiatric information._____(initial)
2. I may refuse to sign this authorization or revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. If I request , I will receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the Protected Health Information as stated.

Signature of Patient/Guardian/Patient Representative: Date:

Print Name of Patient's Representative: Relationship to Patient: