MEDICAL RELEASE FORM

Authorization for Use or Disclosure of Information

_____ **(Please *print* patient name)** _____ **(Date of Birth)**

hereby authorizes and directs _____ **(Former health care provider)**

_____ **(Phone)** at _____ **(Name of Practice/Hospital)** _____ (Fax)

to disclose the following protected health information about this patient to:

Dr. Caryn Garriga, MD
249 Clarkson Road, Suite 102; Ellisville MO 63011
Phone: 636-527-8900; FAX: 636-527-8912

Check the applicable health information to be released below:

___ Entire Record
___ Most Recent History/Physical
___ Immunization Record
___ X-ray/Imaging Reports
___ Consultation Reports
___ Lab Results
___ Other (_____)

I understand that this authorization may include information relating to AIDS, HIV, Psychiatric Care, Behavioral/Mental Health Services, Treatment for Drug Abuse or Genetic Testing.

I understand that this information disclosed may be subject to re-disclosure by the recipient and no longer be protected by former health care provider and/or their staff and they are hereby released from any legal responsibility/liability for disclosure of the information requested.

This authorization will expire 90 days from the date set forth below. When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice listed above has acted in reliance upon this authorization. My written revocation must be submitted to the practice above.

I acknowledge and understand that the former health care provider may not condition enrollment or eligibility for benefits upon my granting this authorization.

Printed **Name of Parent/Legal Guardian/Patient** _____

Signature **of Parent/Legal Guardian/Patient** _____

Date: _____ **Relationship to Patient: _____**

Purpose for disclosure: _____
(Moving/Changing Doctors/Claiming Benefits or Services/Personal Copy)

NOTE to RECIPIENT: ***This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws (including HIPPA) and prohibits you from further disclosure without the written consent of the person to whom it pertains. A copy of this form will be filed in the patient's file.***