(Patient Name) (Pt. ID #)

Assignment of Benefits / Authorization to Release Information

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Orthotic & Prosthetic Lab, Inc. for any covered services furnished by Orthotic & Prosthetic Lab, Inc. I agree to pay to Orthotic & Prosthetic Lab, Inc. the deductible and/or coinsurance on my claim or any of my dependent(s). I further agree that should the amount be insufficient to cover the entire orthotic or prosthetic expense, I will be responsible for payment of the difference, and if the nature of the disability be such that it is not covered by the policy, I will be responsible to Orthotic & Prosthetic Lab, Inc. for payment of the entire bill.

I also understand that telephone inquiries to my insurance company ***ARE NOT*** **a guarantee of coverage/benefits**. We (Orthotic & Prosthetic Lab, Inc.) have attempted to estimate your balance due; however, after review by your insurance company, you may owe an additional amount.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or my physician or I fail to provide within (30) days the information necessary to submit the claim for payment.

☐ **By checking this box and signing below, I acknowledge receiving a copy of Notice of Privacy Practices (NPP)**

Patient or Representative Signature: _____ Date: _____

If Representative, please complete below.

Printed Name: _____

Address: _____ City State Zip

Relationship to Patient:_____ Reason for Patient's Inability to Sign: _____

For Notice of Privacy practices only, describe the Personal Representative's authority to act on behalf of the patient:

_____

Please list any individuals we may speak to or release information to:

I authorize the following individuals, including myself to have access to information regarding self/patient.

_____ _____

Please print name relationship to patient

_____ _____

Please print name relationship to patient

Pediatrician Name and phone # _____

Signature: _____ Date: _____

ORTHOTIC & PROSTHETIC LAB, INC.
Patient History Form

Patient Name:_____ Today's Date: _____

Date of Birth: _____ ☐ Male ☐ Female Ethnic Background: _____

Birth Weight: _____ Birth Length: _____ Number of week at birth: _____

Full Term ☐ Premature ☐ Time spent in NICU: _____

Other Congenital anomalies or medical conditions: ☐ None

☐ Congenital Muscular Torticollis ☐ Ear Infections ☐ Scoliosis

☐ Developmental Delays ☐ Equinovarus ☐ Genu varum

☐ Congenital hip dislocations Other: _____

Maternal Factors:

First Pregnancy? ☐ Yes ☐ No Abnormal uterus/pelvis? ☐ Yes ☐ No Age: _____

Unusual position in utero? ☐ No ☐ Yes – Explain: _____

Delivery Information (check all that apply):

☐ Single Birth ☐ Multiple Birth ☐ Head Down ☐ Breech ☐ Forceps

☐ Suction ☐ Cesarean ☐ Vaginal Other _____

Other:

☐ Reproductive Assistance ☐ Drugs to prolong Pregnancy ☐ Excess/lack of amniotic fluid

☐ Epidural or spinal Other Delivery complications: _____

Preferred sleeping position: ☐ Back ☐ Tummy ☐ Side ☐ Mixed

Head shape at birth: ☐ Symmetrical ☐ Asymmetrical ☐ Wide ☐ Long

Other _____

ORTHOTIC & PROSTHETIC LAB, INC.
Patient History Form

At what age did you first notice your child's head was abnormally shaped? _____

If applicable, do any of your other children have abnormally shaped heads? _____

Has repositioning been attempted? ___ No ___ Yes – At what age was it started? _____

____ increased belly time ____ used positioning devices

____ turned head at night ____ other _____

Duration of the repositioning? _____ Still repositioning? ___ No ___ Yes

Does your baby have any neck tightness? ___ No ___ Yes -At what age was it noticed? _____

Is your child receiving therapy for this condition? ___ No ___ Yes – For how long? _____

FOR OFFICE USE ONLY:

Measurements (mm):

_____	_____	_____
Circumference	M-L	A-P

Cranial Vault Asymmetry:

_____	_____
Right – Ant. To Left Post.	Left – Ant. To Right Post.

Cephalic Index:

ML / AP _____

_____ mm

Orthotic & Prosthetic Lab, Inc.

(This information is necessary for our files and will be considered confidential) Pt ID#: _____

Patient's Full Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Sex M / F Birthdate _____
Home Phone #_____ Cell Phone # _____ _____
Social Security #_____
Guardian name _____
Guardian SS#_____ **Guardian's date of birth:** _____
*Emergency Contact _____ Phone # (__)_____

Email Address _____

Referring Physician _____
Primary Care Physician _____

PRIMARY INSURANCE

Name of Insured _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Social Security #_____ Home Phone #_____Cell #_____
Relationship to Patient: Self /Spouse/Parent/Other Name of Insurance _____
Insurance ID# _____ Ins. Group #_____
Place of Employment _____ Employer Phone # _____

SECONDARY INSURANCE

Name of Insured _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Social Security #_____ Home Phone #_____Cell #_____
Relationship to Patient: Self /Spouse/Parnt /Other Name of Insurance _____
Insurance ID# _____ Ins. Group #_____
Place of Employment _____ Employer Phone # _____

Patient Name: _____
Patient ID # : _____

Patient Contact Protocol

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondences to the individuals office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ **Primary Phone**: _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ O.K. to talk to Spouse and leave detailed information

☐ **Secondary Phone**: _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Written Communication**
- ☐ O.K. to mail information to home address
- ☐ O.K. to e-mail (must provide e-mail address) _____

_____

☐ **Other:** _____

_____ _____

Patient or Guardian Signature Date

_____ _____

Print Name/Relationship Birthdate of Patient

Patient Id#: _____ Patient Name: _____
Invoice#: _____

O & P Cranial Remolding Orthosis
Patient Pay Agreement

At Orthotic & Prosthetic Lab, we believe everyone should have the right to quality, affordable orthotic care. With this in mind we are happy to offer the parents of infants who need a cranial orthosis a substantial discount and reasonable payment plan when their insurance will not cover a cranial remolding orthosis.

The retail cost of a cranial remolding orthosis is $3,800.00. In the event that the helmet is an exclusion on your insurance policy and the infant's parent or guardian agrees to abide by the terms and conditions of this plan then the cranial orthosis is discounted down to $1800.00. If we submit a claim to your insurance carrier and they process your claim then this agreement becomes void and you will be subject to the full cost of the insurance allowable/patient responsibility applied by your insurance carrier.

TERMS AND CONDITIONS
A $600.00 dollar deposit is required upfront in order to begin fabrication of your cranial remolding orthosis.

The next payment of $600.00 dollars will be at your 30-day checkup appointment, which is scheduled for _____. Please note, all follow up appointments are at no charge and included in the original cost of your cranial remolding orthosis. Keeping these appointments are critical to the success of your child's remolding therapy.

The final $600.00 dollar installment is due at your 60-day checkup appointment, which is scheduled for: _____ .

Payments must be received before or on the scheduled dates named above. Failure to keep an appointment or the rescheduling of an appointment does not absolve the parents or guardian from the responsibility of meeting these payment deadlines. **If the guarantor defaults on any of the payments outlined in this agreement then the patient pay discount is forfeited and the remaining amount figured on the actual cost of the cranial remolding orthosis ($3,800.00) will be due the day after the default occurs.**

ENTIRE AGREEMENT. This Agreement contains the full, and final agreement between the parties with respect to the subject matter contained herein and supersedes all prior negotiations, discussions and agreements. This agreement cannot be modified or amended, except in writing, signed by the parties hereto.

I agree to the terms and conditions set forth in this agreement, ACKNOWLEDGED, RATIFIED, AND AGREED TO THIS _____ DAY OF _____, 20____.

_____ _____
Parent, Guardian or Guarantor's Signature Print Name

ORTHOTIC AND PROSTHETIC LAB, INC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact: our Privacy Contact who is Tom Malone 314-968-8555

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Your "protected health information" means any of your written and oral health information, including your demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

We are strongly committed to protecting your medical information. We create a medical record about your care because we need the record to provide you with appropriate treatment and to comply with various legal requirements. We transmit some medical information about your care in order to obtain payment for the services you receive, and we use certain information in our day to day operations. This Notice will let you know about the various ways we use and disclose your medical information, describe your rights and our obligations with respect to the use or disclosure of your medical information. We will also ask that you acknowledge receipt of this Notice the first time you come to or use any of our facilities, because the law requires us to make a good faith effort to obtain your acknowledgment.

We are required by law to:

Make sure that any medical or health information that we have that identifies you is kept private, and will be used or disclosed only in accord with this Notice of Privacy Practices and applicable law;

Give you this Notice of our legal duties and our privacy practices; and

Abide by the terms of the Notice of Privacy Practices that is in effect from time to time.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Protected Health Information for Treatment, Payment and Healthcare Operations

Your protected health information may be used and disclosed by your Orthotist or Prosthetist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of O & P Lab, Inc.

Following are examples of the types of uses and disclosures of your protected health care information that O & P Lab, Inc is permitted to make. We have provided some examples of the types of each use or disclosure we may make, but not every use or disclosure in any of the following categories will be listed.

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to the physician that referred you to us. We will also disclose protected health information to other health care providers who may be treating you when we have the necessary permission from you to disclose your protected health information.

For Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We may also tell your health plan about an orthotic or prosthetic device you are going to receive to obtain prior approval or to determine whether your plan will cover the device.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of O&P Lab, Inc. These activities include, but are not limited to, quality assessment activities, employee review activities, legal services, licensing, and conducting or arranging for other business activities. We may share your protected health information with third party “business associates” that perform various activities (e.g., billing, transcription services) for this O&P Lab, Inc. Whenever an arrangement between O&P Lab, Inc and our business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Treatment Alternatives: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Appointment Reminders: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sign In Sheets: We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your Practitioner is ready to see you.

Marketing and Health Related Benefits and Services: We may also use and disclose your protected health information for other marketing activities. For example, we may send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Sale of the Practice: If we decide to sell this practice or merge or combine with another practice, we may share your protected health information with the new owners.

B. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing. You understand that we can not take back any use or disclosure we may have made under the authorization before we received your written revocation, and that we are required to maintain a record of the medical care that has been provided to you. The authorization is a separate document, and you will have the opportunity to review any authorization before you sign it. We will not condition your treatment in any way on whether or not you sign any authorization.

C. Other Permitted and Required Uses and Disclosures That May Be Made Either With Your Agreement or the Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your Practitioner may, using their professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, orally or in writing, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition.

D. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to object.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. A disclosure under this exception would only be made to somebody in a position to help prevent the threat to public health

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. We will only make this disclosure if you agree or when required or authorized by law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Military and Veterans: If you are a member of the military, we may release protected health information about you as required by military command authorities.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes might include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the O&P Lab, Inc's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: Under certain circumstances, we may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs that provide benefits for work-related illnesses and injuries.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility. O&P Lab, Inc and your Orthotist or Prosthetist created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.

2. YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information contained in your medical and billing records and any other records that your Practitioner uses for making decisions about you, for as long as we maintain the protected health information.

To inspect and copy your medical information, you must submit a written request to the Privacy Contact listed on the first and last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

We may deny your request in limited situations specified in the law. For example, you may not inspect or copy psychotherapy notes; or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain other specified protected health information defined by law. In some circumstances, you may have a right to have this decision reviewed. The person conducting the review will not be the person who initially denied your request. We will comply with the decision in any review. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as

described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Practitioner is not required to agree to a restriction that you may request. If the **Practitioner** believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your **Practitioner** does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your **Practitioner**. You may request a restriction by submitting your request in writing to our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your Practitioner amend your protected health information. This means you may request an amendment of your protected health information contained in your medical and billing records and any other records that your **Practitioner** uses for making decisions about you, for as long as we maintain the protected health information. You must make your request for amendment in writing to our Privacy Contact, and provide the reason or reasons that support your request.

We may deny any request that is not in writing or does not state a reason supporting the request. We may deny your request for an amendment of any information that:

1. Was not created by us, unless the person that created the information is no longer available to amend the information;
2. Is not part of the protected health information kept by or for us;
3. Is not part of the information you would be permitted to inspect or copy; or
4. Is accurate and complete.

If we deny your request for amendment, we will do so in writing and explain the basis for the denial. You have the right to file a written statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right only applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It also excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. You must submit a written request for disclosures in writing to the Privacy Contact. You must specify a time period, which may not be longer than six years and cannot include any date before April 14, 2003. You may request a shorter timeframe. Your request should indicate the form in which you want the list (i.e., on paper, etc). You have the right to one free request within any 12 month period, but we may charge you for any additional requests in the same 12 month period. We will notify you about the charges you will be required to pay, and you are free to withdraw or modify your request in writing before any charges are incurred.

You have the right to obtain a paper copy of this notice from us, upon request to our Privacy Contact, or in person at our office, at any time, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you in any way for filing a complaint, either with us or with the Secretary.

You may contact our Privacy Contact, Tom Malone at (314) 968-8555 or by e-mail at tmalone@oandplabinc.com for further information about the complaint process.

4. CHANGES TO THIS NOTICE

We reserve the right to change the privacy practices that are described in this Notice of Privacy Practices. We also reserve the right to apply these changes retroactively to Protected Health Information received before the change in privacy practices. You may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of your next appointment.

This notice was published and becomes effective on April 14, 2003.

ORTHOTIC & PROSTHETIC LAB INC.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Orthotic & Prosthetic Lab, Inc Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Orthotic and Prosthetic Lab's** health care operations. The Notice of Privacy Practices also describes my rights and Orthotic and Prosthetic Lab, Inc's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the reception area of the office.

Orthotic and Prosthetic Lab, Inc reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Authorization for Release of Protected Health Information

Patient Identification

Name:_____ **DOB**_____

Address: **SS#** _____

_____ Orthotic & Prosthetic Lab

Information is to be released by **Information is to be released to**

_____ 748 Marshall Avenue

Street address **Street address**

_____ St. Louis, MO 63119

City, State and Zip Code **City, State and Zip Code**

_____ Ph# 314-968-8555 Fax# 888-748-4185

Telephone **Telephone or Fax ____ (please check if to be sent to fax)**

INFORMATION TO BE RELEASED-COVERING THE PERIODS OF HEALTH CARE

From (date)_____ **to (date)**_____

PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED

Complete Health record☐ **Billing**☐ **Diagnosis/Treatment Codes**☐ **Discharge Summary**☐ **Lab Results**☐ **Xray results**☐

Other (specify)_____

Purpose of request_____

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release (check one)

YES☐ **NO**☐

TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Records Department or other department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date_____ or 90 days from date of signature, unless otherwise specified.

RE-RELEASE

I understand the information released pursuant to this authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE

Your provider will not deny treatment if you do not sign this form. BY SIGNING BELOW, YOU AUTHORIZE YOUR PROVIDER, IDENTIFIED, TO RELEASE YOUR PROTECTED HEALTH INFORMATION SPECIFIED ABOVE AS WELL AS AGREE TO PAY ANY FEES THAT MAY APPLY.

SIGNATURE_____ **DATE**_____

AUTHORITY TO SIGN (IF NOT PATIENT)_____ **WITNESS**_____

Identity of requestor verified via: photo ID:____ matching Signature:__ other, specify_____**ID verified by** _____