INTERVENTIONAL PAIN CARE
60 Business Park Dr., Suite A
Troy, MO 63389
P: (636) 728-9460
F: (636) 775-1544

RECEN ORTHO SPINE&PAIN
407 Meramac Blvd
Eureka, MO 63025
P: (636) 333-3701
F: (636) 333-3701

Medical Records Request

PATIENT INFORMATION:

Name: _____DOB:____/____/_____

Street Address: _____Phone: (____) _____-_____

AUTHORIZED OFFICE SENDING RECORDS:

Office/Provider's Name: _____

Street Address: _____ Phone: (____) _____-_____ Fax: (____) _____-_____

PURPOSE FOR NEED OF DISCLOSURE: ☐ Continue Care ☐ Begin Care

INFORMATION TO BE RELEASED: Dates ___/___/_____ to ___/___/_____ OR the last _____.

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ EKG/Cardiology Reports
- ☐ Current Medication List
- ☐ Medical History
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Current Office Notes
- ☐ **Entire Record**
- ☐ Other (Specify):_____

In compliance with MO Statues, which require special permission to release otherwise privileged information, please release records including mental health, Developmental Disabilities, Alcoholism, HIV (AIDS), Sexually Transmitted Disease and Drug Abuse.

[Signer must initial if in agreement] _____

I do not wish the following information to be released:

_____

PATIENT'S RIGHT WITH RESPECT TO THESE AUTHORIZATIONS:

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information to be contacting Medical Records. I have the right to receive a copy of this authorization. I understand that I agree to sign this authorization, which I am not required to do. I must be provided a signed copy of the form. Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person or organization above who I am authorizing to use and or disclose my information may not condition treatment, payment enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to withdraw this authorization: I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, I may contact Medical Records, I am aware that my withdraw will not be effective as to uses and or disclosures of my health information that the persons and/or organizations listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good for **one year** from the date signed.

I have had the opportunity to review and understand the content of the authorization form. By signing this authorization, I am confirming that it adequately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP:_____**DATE: ___/___/_____**

This information disclosed to you may be from records protected by Federal confidentiality Rules (42CFR part 2) or by section 191.656.RS.MO (1991). The federal rules and Missouri law prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR part 2 or section 191.656. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that if the persons or organizations listed above are not health care providers, health plans or health care clearinghouse. Who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Please fax requested records to 636-775-1544.