SAINT LOUIS ASSOCIATES IN

Mercy Hospital
621 South New Ballas Road STE 1017B
ST Louis, MO 63141
p. 314.993.6401
f. 314.993.5475

Progress West
20 Progress Point Parkway STE 126
O'Fallon, MO 63368
p. 314.993.6401
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AUTHORIZATION FOR REQUEST / RELEASE OF MEDICAL RECORDS

Patient Information:

Name (Please Print) ____
Last First Middle Initial Maiden (if applicable)

Birth Date:_________/_________/__________
Month Day Year

I hereby request and authorize the release of my medical records:

<u>From:</u> Name:____

Street:____

City:___________________State:______________Zip;__________

Phone: (_____)______-_________ Fax: (_____)______-_________

<u>To:</u> Name:____

Street:____

City:___________________State:______________Zip;__________

Phone: (_____)______-_________ Fax: (_____)______-_________

Records to be released: (Please specify)

All:_______________________________

OR

____

Reason for request:

Transfer of care _________

Second opinion _________

Primary care physician _________

Other _________

____ Date
Signature of patient or guardian

____ Date
Signature of witness