

I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

 Yes, I consent to the release of this information
Initial

 No, I do not consent to the release of this information
Initial

- This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time by sending a written notice of revocation to:
 - Health Information—Release Services
 - Campus Box 1219
 - 7425 Forsyth, Suite 301
 - St. Louis, MO 63105-2161
 - Office Phone: 314-935-0453 Fax: 314-935-0965
- The revocation will not apply to information already released in response to this authorization.
- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.
- I understand that once my information is used and/or disclosed pursuant to this authorization, it may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient(s).
- I understand that a reasonable fee may be charged unless copies are sent to another physician or healthcare facility.

Authorization is valid either for 90 days from the date of signature (if not otherwise specified) OR as specified by selecting one of these options:

This authorization expires on the following date _____

This authorization expires due to the following event or special condition _____

I have read and understand this consent and I have signed it voluntarily.

(Signature of patient or Parent/Legal Representative)

(Date)

(Relationship to Patient)

(Witness)

(Date)

(Patient's Address, City, State, Zip)

(Patient's Phone)

(Certified copy of appointment of legal guardian or personal representative and death certificate of deceased patient must be attached)