The Orthopedic Center of St. Louis

14825 North Outer Forty Road, Suite 200

Chesterfield, Missouri 63017

Main Line: 314-336-2555 Fax Line: 314-392-5083

Authorization For Release Of Information or Individual Access To Information

This form allows TOC to release medical records from our office and does not allow us to request records from another physician's office.

I hereby authorize TOC to release medical information of: _____

Date of Birth: _____ Social Security Number: _____

Which doctor are you requesting records from: (Circle ALL that apply)

Dr. Matthew Gornet Dr. John Krause Dr. Sri Pinnamaneni

Dr. John Webb Dr. Chris Reeves

Other: _____ Copy of Imaging All Records

Dates of Treatment: _____

Release or Mail to: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax (For Patient Request, State "Self"): _____

Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulation and may no longer be deemed "confidential." I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use of psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither The Orthopedic Center of St. Louis nor any affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization, this Authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax, or bring the letter to the address or fax number noted at the top of this page.

Patient/Legal Representative Signature: _____

Date: _____ Relationship to Patient: _____

Send Records by: ____ Mail ____ Fax ____ Email