MOSAIC family medicine

WEB: www.mosaicfamilymed.com | ADDRESS: 103 North Taylor Ave., Suite C, Kirkwood, MO 63122 | PHONE: 314-380-4566 | FAX: 314-743-3700

Authorization To Release Healthcare Information

Patient Name:

Date of Birth: Phone Number:

Address:

City: State: ZIP:

I request and authorize the release of the healthcare information of the patient named above.

FROM:

Doctor's Name:

Practice Name:

Address:

City: State: ZIP:

Phone: Fax;

TO:

SANDRA MINCHOW-PROFFITT, MD
MOSAIC FAMILY MEDICINE LLC
103 NORTH TAYLOR AVE., SUITE C
KIRKWOOD, MO 63122

PHONE: 314-380-4566
FAX: 314-743-3700

Reason for request:

This request and authorization applies to healthcare information relating to the following treatment, condition, or dates:

☐ All healthcare information

OR

☐ Some healthcare information. Mark all that apply:

- ☐ Progress notes for the past _____ months
- ☐ OB record
- ☐ Hospital notes, specialist consult notes, and discharge summary
- ☐ Lab reports
- ☐ Imaging/XRay results
- ☐ Shot record
- ☐ Most recent physical, occupational and speech therapy note
- ☐ Surgical reports

☐ Yes ☐ No I authorize the release of my HIV/AIDS testing, whether negative or positive, to the practice listed above. I understand that the practice listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Guardian Signature: Date signed:

THIS AUTHORIZATION EXPIRES 6 MONTHS AFTER IT IS SIGNED.