

WOMEN'S HEALTH SPECIALISTS OF ST. LOUIS, LLC

456 N NEW BALLAS ROAD, SUITE 386 CREVE COEUR, MISSOURI 63141

AUTHORIZATION OF RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I, the undersigned, hereby authorize _____ to release information contained in my medical records to:

Name: Women's Health Specialists of St. Louis, LLC
456 N New Ballas Road, Suite 386
Creve Coeur, Missouri 63141
Phone: (314) 292-7080 Fax: (314) 292-7095

I, the undersigned, hereby authorize Women's Health Specialists of St. Louis, LLC, Teresa L. Knight, MD, and/or Laura K. Eastep, MD, to release confidential information contained in my medical records to:

Name: _____
Address: _____
City, St, Zip: _____
Fax #: _____

The confidential information from my medical records to be released is to be limited to the following dates / conditions: _____

If full release of all information in record is authorized, please specify "No Limitations".

I authorize the release indicated above for the following purpose (please indicate the specific reason for disclosure of this information): _____

I release *Women's Health Specialists of St. Louis, LLC* from all legal responsibility or liability that may arise from this authorization. I understand that this release may be revoked as long as I provide the notice in writing. Also, I understand that this authorization is voluntary and that treatment by the healthcare provider cannot be conditioned on the signing of this authorization. I further understand and agree that once this Protected Health Information (PHI) is disclosed it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

(Signature of Patient)

(Date of Release)

(Printed Name of Patient)

(Date of Birth)

(Address, City, State, Zip)

This authorization for release of confidential medical information is void ninety (90) days after the date of its execution unless expressly revoked in writing at an earlier time.