



Mario A. Salinas F.A.C.O.G.  
Jennifer K. McDonald DO F.A.C.O.G.

St. Anthony's Medical Center  
10004 Kennerly Rd  
Suite 295B  
St. Louis, MO 63128

St. Luke's Hospital  
224 S. Woodsmill Rd  
Suite 480 South  
Chesterfield, MO 63107

Office (314) 849-3500

Fax (314) 849-4422

Exchange (314) 364-5424

### AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Patient (PLEASE PRINT)

Social Security #

Date of Birth

Street Address

City, State, Zip

Maiden or other names used for records

DATE THIS AUTHORIZATION EXPIRES *(if no expiration date indicated  
Authorization will expire 1-year from the date of signature)*

#### RELEASE FROM:

#### RELEASE TO:

Name (PLEASE PRINT)

Name (PLEASE PRINT)

Address

Address

City, State, Zip

City, State Zip

The following protected health information is to be disclosed: *(please check all that apply)*

- Complete health record
- Surgical notes
- Pregnancy records
- Other \_\_\_\_\_

Covering the period from \_\_\_\_\_ to \_\_\_\_\_

**Unless specifically indicated, only up to the last three years of records will be copied**

Purpose of Release: *(please check all that apply)*

- Transfer of care
- Moving
- Continuation of care
- Other \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Personal Representative of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Description of Representative's Authority to Act for Patient: \_\_\_\_\_

Representative's Address and Phone Number: \_\_\_\_\_

HIPAA005 03/06