856 Waterbury Falls Drive
Suite 100
O'Fallon, MO 63368
Phone: 636-244-5004
Fax: 636-244-5006

Medical Records Request Form

I, ____, born _____________

Hereby authorize:

____

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To release the following information contained in my chart to Dr. James Sturm.

- o The entire medical record, excluding psychotherapy, substance abuse treatment and HIV acquired immune deficiency syndrome (AIDS) records.
- o Psychotherapy
- o HIV/AIDS information
- o X-Ray reports only
- o Substance Abuse Treatment
- o Lab reports only
- o Other: ____

The above information for the following period of time shall be released:
From Dates: ______________________ to _________________________
The purpose(s) of the authorization is/are:

____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
I understand that this authorization is valid until it expires or is revoked before that time.
I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on ________________.

Signed: ____ Date: ____________________

Witness Signature: ____