AUTHORIZATION for DISCLOSURE

SAINT LOUIS UNIVERSITY. EST. 1818

SLUCare® Physician Group

Health Information Management
Center for Specialized Medicine
1225 South Grand Blvd Garden Level
St. Louis Mo 63104-1016
314-977-6017

I authorize Saint Louis University/SLUCare to release the following information

Patient's Name / Previous Names:

_____

_____

Birth Date Social Security Number Medical Record #

RECIPIENT **(person or organization that will receive your information)**

Patrick Yeung, MD at Veritas Fertility and Surgery

(Doctor / Hospital / Attorney / Insurance Company / Self / etc.)

522 N. New Ballas Rd, Suite 300, St. Louis, MO 63141 (314) 405-9556

_ Address (Street, City, State, ZIP code) Phone Number

FORMAT: ☐ Paper ☒ Electronic (CD) ☐ MyChart (Requests to Self Only)

DESCRIPTION of INFORMATION to be RELEASED

Check items that apply:

☐ Psychotherapy notes **If you check this box, you may not check another box below.**

Federal law requires a separate authorization to use or release psychotherapy notes.

☐ All SLU*Care* Records

☐ All Records (*including outside provider records*)

Specific Information Only *(May list specific incident or identify body region)*

- ☒ Summary of Medical History/Treatment
- ☒ Laboratory / Diagnostic Tests
- ☐ Immunization Records
- ☐ Pathology Reports(s) (SLU*Care*)
- ☒ Radiology Reports
- ☐ Operative Report (SLU*Care*)
- ☒ Progress Note
- ☐ Psychological Testing
- ☐ After Visit Summary
- ☐ EKG Report
- ☐ EEG Report
- ☐ Genetic Testing
- ☐ Billing Information
- ☐ Other_____

_____

Outpatient, Date(s) of Service: office notes, imaging, and lab results from the past 12 months

Records from Specific Provider(s) Patrick Yeung, MD

Body Region / Incident _____

Note : This authorization does not allow release of radiology films, pathology slides.

PURPOSE of DISCLOSURE

- ☒ Continuing Medical Care
- ☐ Social Security/Disability
- ☐ School
- ☐ Military
- ☐ Other (specify) _____
- ☐ Legal Purposes
- ☐ Insurance
- ☐ Patient's Request

I understand that the specific information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including human immunodeficiency virus, (HIV) and acquired immune deficiency syndrome (AIDS), or specific information which requires release by a minor. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice.

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that fees may be associated with this request for medical information.

APPROVAL **(You must sign and date this form for completion.)**

Patient:

_____ _____

(Print Name) (Date)

_____

(Signature)