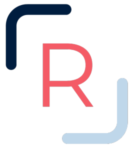

Medical Record Release
5595 Pershing Ave
St Louis, MO 63112
medicalrecords@rezilienthealth.com

Authorization to Release Medical Information

Patient

First & Last Name ______________________ Date of Birth ____________

Address ______________________ State ________ Zip Code ____________

I authorize Rezilient Health to discuss my health information with, and

Select One: ____ RELEASE my medical records to **OR** ____ OBTAIN my medical records from

Third Party

Institution or Individual (First & Last Name) ______________________

Address ______________________ State ________ Zip Code ____________

Phone ______________________ Fax ______________________

Protected Health Information to be Released

Initial below to authorize the release of SENSITIVE information

____ **YES,** release the Sensitive Information selected below

- ☐ Substance abuse, diagnosis or treatment
- ☐ HIV/AIDS testing, status, diagnosis or treatment
- ☐ Psychiatric information
- ☐ STI testing, diagnosis or treatment
- ☐ Genetic testing information
- ☐ BIometric information

Or

____ **NO,** DO NOT release any Sensitive Information

☐ Share ALL categories of records (other than sensitive information)

Or select individual records to share

- ☐ Billing records
- ☐ EKG/EEG/EMG results
- ☐ Genetic records
- ☐ History & physical exam
- ☐ Insurance information
- ☐ Laboratory results
- ☐ Other :
- ☐ Medication list
- ☐ Office visit notes
- ☐ Pathology reports
- ☐ Progress notes
- ☐ Radiology records
- ☐ Referrals

Specify the date or time period for the information to be released

From Date ______________ To Date ______________

Turn over to sign ,.

The purpose of this release is *(Check all that apply)*

- ☐ At the request of the patient
- ☐ Continued patient care
- ☐ Insurance
- ☐ Attorney/Legal request
- ☐ Disability/ Social Security
- ☐ Worker's Compensation
- ☐ Other:

My Rights *(Initial each statement to confirm your agreement)*

_____ I understand that this Authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on my signing this Authorization, except if the Authorization is for:

1) conducting research-related treatment ,
2) to obtain information in connection with eligibility or enrollment in a health plan,
3) to determine an entity's obligation to pay a claim, or
4) to create health information to provide to a third party.

_____ I understand that I may revoke or alter this Authorization at any time, that I must do so in writing and submit it to Rezilient Health. However, I understand if I revoke this Authorization, it will not have any effect on actions Rezilient Health took before they received my revocation.

_____ Once this health information is disclosed, how the recipient further discloses it may no longer be protected under privacy laws such as HIPAA.

_____ I understand that I am entitled to request and receive a copy of this Authorization.

Expiration of Authorization

Unless otherwise revoked, this Authorization expires

Applicable Date or Event ______________________________

If no date is indicated, this Authorization will expire 24 months after the signing of this form.

I have read and understand the information in this Authorization. Please note some outside facilities require a fee in order to release medical records. This fee, if applicable, will be the patient's responsibility.

Signature of Patient ______________________________ Date ____________

Printed Name ______________________________

Signature of Authorized Representative ______________________________ Date ____________

Printed Name ______________________________

Relationship to the patient/authority to act for the patient ______________________________

Witness or Intepreter ______________________________

Email or Mail to:

Medical Record Release
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St Louis, MO 63112
medicalrecords@rezilienthealth.com