



Authorization to use or Disclose Protected Health Information

I authorize the disclosure of protected health information (PHI) from my health record to the individual or facility listed below.

Patient name: _____ Medical Record Number: _____

Date of Birth: _____ Social Security Number: _____

Phone Number: _____

Name and Address of Recipient:

To:

Darin M. Minkin
2355 Dougherty Ferry Road, Suite 430
St. Louis, MO 63122
(314) 965-8410-office
(314) 965-8756 – Fax

From:

Name: _____
Address: _____

Phone: _____
Fax: _____

Specific Description of the purposes of the disclosure: Please check in box for all the apply	
<input type="checkbox"/>	Bariatric Treatment Referral
<input type="checkbox"/>	Insurance Coverage of Payment
<input type="checkbox"/>	Continued Patient Care
<input type="checkbox"/>	Other (specify)

I understand that I may revoke this authorization at any time, with some exceptions, that being to the extent the office or hospital has acted on this authorization prior to the date we received the letter to revoke authorization.

To revoke my authorization, I must submit a written request to the _____
Insert Practice Name

Signature of Patient

Date

Signature of Legal Representative

Relationship to Patient or Description of Authority for patient

Notice to recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information without express written consent of the person to whom it pertains.

Verification of Patient ID:

Signature of person disclosing information to recipient

Date when information was disclosed

Form of ID reviewed by person disclosing information to recipient. (Photo ID and/or signature when authorization was mailed.)