SUBURBAN SURGICAL
555 NORTH NEW BALLAS ROAD, STE 265
ST. LOUIS, MO 63141
Telephone: 314-991-4644
Fax: 314-991-4910

Authorization for Release of Information

Name: ____ **Date of Birth:** ________________________________

Address: ____ **City, State, Zip:** ______________________________

Patient Phone Number: ____

☐ **I authorize the Suburban Surgical to release information to:**	**AND/OR**	☐ **I authorize the Suburban Surgical to obtain information from:**
______________________________________ **Name of Provider or Facility**		______________________________________ **Name of Provider or Facility**
______________________________________ **Address**		______________________________________ **Address**
______________________________________ **City, State, Zip Code**		______________________________________ **City, State, Zip Code**
______________________________________ **Phone #/Fax # (Include area code)**		______________________________________ **Phone #/Fax # (Include area code)**

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **History/Physical** ☐ **Progress Notes** ☐ **Laboratory Test Results**_______________________________

☐ **Discharge/Admit Summary** ☐ **Diagnostic testing** ___________________________________

☐ **Other:** ____

Disclosure: I authorize the use of this disclosure of the information described above to the person/provider/organization/facility/program(s) identified from date __/__/____ or revocation.

Signature of Patient or Representative: ____

Date: __________________

I understand that:

- I may cancel this authorization at any time by submitting a *written* request to Suburban Surgical office.
- The information is not for secondary Release.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations..
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