DT2008

This authorizes **St. Anthony's Medical Center:** to:
PERSON(S), CLASS OR ORGANIZATION

☐ **OBTAIN a copy of my Protected Health Information contained in my medical record to:**

☒ **RELEASE a copy of my Protected Health Information contained in my medical record to:**

Name RECORDS DEPOSITION SERVICE, INC. **Address** 120 W. MADISON ST., STE. 300, CHICAGO, IL 60602

P: 312-553-8900 F: 312-553-8901

Date(s) of Treatment _____ ☐ Inpatient ☐ Outpatient ☐ Emergency Room

☐ Other (specify) _____

The information to be released or disclosed is:

☐ Radiology reports ☐ Emergency room reports ☐ Operative reports ☐ Lab reports

☐ Abstract (transcribed reports, test results, EKGs, face sheets)

☒ Other **Please see enclosed Subpoena or Letter Request for information to be disclosed.**

The information indicated above is to be used and/or disclosed for the following purpose(s):

FOR DISCOVERY BEFORE TRIAL

COMPLETE THE FOLLOWING INFORMATION IF ST. ANTHONY'S MEDICAL CENTER IS REQUESTING THE AUTHORIZATION:

To be completed by St. Anthony's Medical Center:
Is St. Anthony's Medical Center receiving some form of compensation in exchange for using or disclosing the Protected Health Information described above? (check one) ☐ YES ☐ NO

To be read by patient prior to signing:

I understand that I may refuse to sign this authorization.

I understand that my treatment at or by St. Anthony's Medical Center or payment for that treatment will not be affected if I do not sign this authorization.

I understand that I may request to inspect and copy the information that is to be used and/or disclosed pursuant to this authorization.

I understand that I should receive a copy of this authorization after I sign it.

This authorization expires on _____ or within 90 days of the date signed if I have not provided an
DATE OR EVENT
expiration date or an expiration event.

Once my health information is disclosed, I understand that it may no longer be protected by privacy laws.

I understand I may revoke this authorization at any time by notifying St. Anthony's Medical Center, in writing, at the above address, but that any such revocation will not have any effect on any actions taken before receiving the revocation.

IMPORTANT: I understand that authorized disclosures may contain Protected Health Information containing diagnosis, treatment and other information regarding psychiatric and mental health, substance abuse (chemical dependency), HIV and/or AIDS, unless I specifically request that such information not be disclosed.

I understand that I can receive a copy of this authorization if I request it.

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE *DATE*

If signed by patient's representative, indicate relationship to the patient _____

Telephone number where patient may be contacted _____

St. Anthony's Medical Center
St. Louis, Missouri 63128

Health Information Management Department

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____
PATIENT'S NAME (print name)

_____
DATE OF BIRTH

_____
MEDICAL RECORD NUMBER

_____
SOCIAL SECURITY NUMBER