Stella Maris Internal Medicine
& Center for Medical Weight Loss
12855 North Forty Drive, Suite 350
St. Louis, MO 63141
Phone 314-205-1926
Fax 314-205-1076

Patient Name:_____
Last First Middle

DOB: _____ Social Security Number: _____

I authorize and request: _____

_____

_____
Name and Address of Individual/Agency

To Release to: _____

_____

_____
Name and Address of Individual/Agency

Medical Records covering the periods of health care from _____ to _____

Information to be released: (NOTE: The patient must check and initial if the following information is to be released)
- ☐ OB/Gyn Records
- ☐ Psychiatric Evaluations
- ☐ HIV Testing and or treatment
- ☐ Substance Use/Abuse History
- ☐ Other (please specify): _____

The medical Record information is needed for: _____

Attention: Once this information has been released pursuant to this authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "confidential."

I understand that neither Stella Maris Internal Maris & Center for Medical Weight Loss nor any of its affiliated health care workers/providers can make me sign this authorization as a condition to getting treatment, making payments, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of the authorization if I so requested it.

I understand that I may revoke this authorization at any time except to the extent that prior action has been taken in reliance on this authorization. The authorization will expire ninety days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax, or bring the letter to the address or fax number the top of the page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate.

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian or other individual if applicable Date Relationship to the patient