Stuart R. Adler, M.D. P.C. - Records

PO Box 410526
St. Louis, Missouri 63141
FAX (920) 351-8702

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____ Middle Initial _____ Last Name _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____

I authorize **Stuart R. Adler, MD PC - Records** or the designated **Custodian of Medical Records** to **disclose** the following medical documentation to:

Physician Office _____ FAX _____

Address _____

City _____ State _____ Zip _____

for the purpose of Continuing Medical Care. This authorization may include **records of visits, office visit notes, diagnoses, lab summaries, medications, and past medical history.**

☐ ____ (initial) I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

1. Any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my prior written authorization.
2. I have the right to inspect or copy the Protected Health Information (PHI) to be used or disclosed.
3. I may revoke this authorization at any time, except where information has already been released, by completing a Revocation of an Authorization form from **Stuart R. Adler, M.D. P.C. - Records** or the designated **Custodian of Medical Records**.
4. This authorization is valid for a 90 day period from the date it is signed, if an expiration date is not provided by me below.
5. A photocopy or fax of this Authorization Form is as valid as the original.
6. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
7. **Stuart R. Adler, M.D., P.C.- Records**, the designated **Custodian of Medical Records** and their workforce members are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Name _____ Date _____

Signature of Patient (or Personal Representative) _____ Relationship to Patient _____

Witness _____ Date _____

Expiration Date (If Other than 90 days from date signed) _____ Revocation Date _____

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Please make checks payable to **Dr. Stuart Adler** and send to the address listed below along with the signed release form and this invoice. To expedite these orders we are capping the charges to a flat fee of $40.00 which includes all state mandated fees. Payment is required prior to sending the medical records.

Dr. Stuart Adler
Record Request
P.O. Box 410526
St. Louis, MO 63141

Total Enclosed **$ 40.00**