The Orthopedic Center of Saint Louis
14825 North Outer Forty Road, Suite 200
Chesterfield, Missouri 63017
Main Line: 314.336.2555 Fax Line: 314.392.5083

Authorization For Release Of Information or Individual Access To Information

This form allows TOC to release records from our office and does not allow us to request records from another physician's office.

I hereby authorize TOC to release medical information of: _____
(Patient's Full Name)

For Names (where applicable): _____

Date of Birth: _____ Social Security Number: _____

Which doctor are you requesting records from:

____ Dr. Mahesh Bagwe ____ Dr. Wendell Becton ____ Dr. David Brown ____ Dr. Luke Choi

____ Dr. Benjamin Crane ____ Dr. Donald deGrange ____ Dr. Matthew Gornet ____ Dr. Lyndon Gross

____ Dr. John Krause ____ Dr. Paul Lux ____ Dr. Nathan Mall ____ Dr. Mark Miller

____ Dr. George Paletta ____ Dr. Mitchell Rotman ____ Dr. Brett Taylor

Dates of Treatment: _____

Release or Mail to: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ For the purpose of: _____
(for patient request, state "self")

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 permit the release of all information indicted above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither TOC (The Orthopedic Center of Saint Louis) nor any affiliated healthcare providers can make me sign this Authorizations as a condition to getting treatment, making payments on any bills, 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 this Authorization if I chose to do 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, This Authorization will expire ninety (90) 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 noted at the top of this page.

Patient/Legal Representative Signature: _____

Date: _____ Relationship: _____