

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
FROM: LAURA WAGNER, INC.**

PATIENT INSTRUCTIONS:

1. Print this form.
2. Complete and Sign.
3. Mail or Fax this form to:

Laura Wagner, Inc.
14377 Woodlake Drive Suite 111
Chesterfield, MO 63017

Phone: 314-434-1111
Fax: 314-434-1112

Patient Name: _____ **Date of Birth:** _____

You are requesting Laura Wagner, MD to send your medical records to:

Provider/Facility Name _____
Address _____
City, State, Zip _____
Phone: _____ Fax: _____

Information to be Released

Check all that apply. circle All Dates or write in the From & To date range

<input type="checkbox"/>	Complete Health Record	All Dates or From:	To:
<input type="checkbox"/>	Laboratory Test Results	All Dates or From:	To:
<input type="checkbox"/>	Pathology Test Results	All Dates or From:	To:
<input type="checkbox"/>	X-ray Reports	All Dates or From:	To:
<input type="checkbox"/>	Hepatitis Information	All Dates or From:	To:
<input type="checkbox"/>	Discharge Summary	All Dates or From:	To:
<input type="checkbox"/>	Other	All Dates or From:	To:

Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization. A photocopy or fax of this authorization is as valid as the original. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for one year from the date it is signed. LAURA WAGNER, INC., it's employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. By signing below, you authorize Laura Wagner, Inc. to release your protected health information to the above named provider.

X _____
Patient's Signature (or Guardian, if patient is a minor)

X _____
Relationship to patient

X _____
Date Signed

X _____
Revocation Date (if other than one year)