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

PATIENT INSTRUCTIONS:

1. **Print this form.**
2. **Complete and Sign.**
3. **Mail or Fax this form to the physician or facility who has the records.**

Your provider will then forward your records directly to Dr. Wagner.

PROVIDERS: Please Mail or Fax these records 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 authorizing the following provider to release your medical records:

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

☐	Complete Health Record	All Dates	*or*	From:	To:
☐	Laboratory Test Results	All Dates	*or*	From:	To:
☐	Pathology Test Results	All Dates	or	From:	To:
☐	X-ray Reports	All Dates	*or*	From:	To:
☐	Hepatitis Information	All Dates	*or*	From:	To:
☐	Discharge Summary	All Dates	*or*	From:	To:
☐	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 the above named provider to release your protected health information to Laura Wagner, Inc.

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)