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AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

I HEREBY AUTHORIZE:

TO OBTAIN FROM:

Organization: _____
 Physician: _____
 Address: _____

 Phone: _____ Fax: _____

With disclosure of medical/surgical information, this may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Patient's Name: _____ Phone: _____
 Date of Birth: _____ SSN: _____
 Purpose: _____

Type/Amount of Information: (Please circle)

Problem List	Consultation	Medication List	Allergies
Immunization Record	Entire Record	Last History/Physical	Last Disch. Summary
Lab Results (Dates)	to	Other	
X ray results (Dates)	to		

I understand it is possible that information disclosed because of this authorization may be re-disclosed by the person receiving it and no longer be protected. I understand that I may revoke this authorization in writing at any time, unless records have already been released because of the original authorization. This authorization will expire 180 days from the date of signature unless otherwise notified in writing.

You have the right to review our Notice of Privacy Practices before signing.

Patient Signature: _____ Date: _____
 Signature of Authorized Representative: _____ Date: _____
 Witness: _____ Date: _____

_____ Staff initials (copy of photo ID obtained)
 _____ Patient initials (receipt of copy of authorization)