David J. Stansfield, D.O., LLC
10279 Business 21
Hillsboro, MO 63050
(636)789-3941 Fax (636)789-5603

Name of Patient: _____ Date of Birth: _____

I hereby authorize David J. Stansfield, D.O. to: _____ disclose/release to, or _____ obtain from

_____
Name of Physician, Hospital or Other

_____
Address, Phone & Fax number

I authorize the following health information to be released:
_____ Entire Medical Record
_____ Immunization Record
_____ Laboratory Results from _____ to _____
_____ X-ray or other imaging from _____ to _____
_____ Other (please specify) _____

For the purpose of:

_____ Transfer of care to another primary physician
_____ Consult with specialist
_____ Other (please specify) _____

Notice: We are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment or health care operations. Specific information about how we can use or disclose your health information can be reviewed in our Notice of Privacy Practices.

I understand that this authorization may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection, psychiatric care, behavioral or mental health services, treatment for alcohol and/or drug abuse and genetic testing.

I understand that the information disclosed may be subject to re-disclosure by the recipient and no longer protected by David J. Stansfield, D.O., LLC. David J. Stansfield, D.O. and his staff are hereby released from any legal responsibility or liability for disclosure of the above information. I also understand that I have the right to read and/or obtain copies of the information to be disclosed.

I understand that I have the right to revoke this consent by written statement at any time; otherwise, it will automatically expire 60 days from the date of authorization. I understand that refusing to sign this form will result in the records not being released.

_____ _____
Patient's Signature or Legal Guardian Date