PARKCREST ORTHOPEDICS, LLC
Authorization for the Release of Information

Patient Name: _____Date of birth: _____

Address: _____ Phone #: _____

_____

I Authorize Parkcrest Orthopedics to disclose copies of my medical records to:

(check appropriate box)

☐ **Myself** (or legal guardian)**:**

- ☐ Mail me my records. (**address must be provided above**)
- ☐ E-mail me my records via secure e-mail; my e-mail address is: _____
- ☐ Fax me my records; my fax number is: _____

☐ **The facility/individual detailed below** (mail, fax, or secure e-mail):

Facility/Individual Name: _____

Address: _____Phone #: _____

_____ Fax #: _____

E-mail address for facility (if applicable): _____

This Authorization extends only to documents checked below:

_____ Any/all medical records
_____ Office Notes Dates: _____ to _____
_____ Lab Results Type of Test: _____ Date(s): _____
_____ Radiology Reports Date Taken/Part of the Body: _____
_____ Itemized Statement of Charges or Payments
_____ Operative Reports Date(s): _____
_____ Mental Health and/or alcohol & drug abuse treatment
_____ AIDS or HIV information
_____ Hepatitis information
_____ Other (specific): _____

This Authorization is given freely with the understanding that:

1. Any and all records, whether, oral or electronic, are confidential and cannot be disclosed without my prior authorization.
2. I have the right to inspect or copy the Protected Health Information to be used or disclosed.
3. A photocopy or fax of this Authorization Form is as valid as the original.
4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.
5. Parkcrest Orthopedics and its workforce members are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
6. 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 1 year from the date it is signed if I do not cancel it in writing prior to the expiration date. Any cancellation must be mailed, faxed or delivered to the address below.
7. Pursuant to the State of Mo statute RSMO Section 191.227, I understand I may be billed by copying service HealthMark for all copies made by HealthMark Group. **The 2023 charge for hard copies made by Parkcrest Orthopedics is $28.57 plus .66 per page pursuant to RSMO 191.227, plus postage if records are mailed**. This fee updates annually.
8. By signing below, I agree to the terms and conditions described above.

_____ _____

Patient's Signature (or personal representative) Date

James Emanuel, MD CIME
Phone: 314-997-1777 Fax: 314-997-6277 Address: 845 N. New Ballas Ct, Ste 130, Creve Coeur, MO 63141