Jeffrey R. Zohner, M.D., LLC
121 St. Luke's Center Drive, Suite 401
Chesterfield, MO 63017
Phone (314) 576-5550
Fax (314) 576-3007

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:____
Address:____
Date of Birth:____________________________

I authorize Jeffrey Zohner, M.D., LLC, to receive the following medical information from:

Name______________________________Contact Name____________
Address____
City, State, Zip____
Telephone Number____________________Fax Number________________
Purpose of Disclosure____

THIS AUTHORIZATION EXTENDS ONLY TO DOCUMENTS CHECKMARKED BELOW:

O	Record of Visits	From____________ To____________
O	Progress Notes	From____________ To____________
O	Lab Results	Type of Test__________ Date__________
O	X-ray & Imaging Reports	Date Taken__________
O	Discharge Summary	Date of Discharge________
O	History & Physical Exam	Date____________
O	Mental Health or Illness	
O	All of the Above	
O	Other (Must be specific)______________________________	

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization.
2. I have the right to inspect or copy the Protected Health Information (PHI) to be used or disclosed.
3. I may revoke this authorization at any time, except where information has already been released, by completing Jeffrey R. Zohner M.D., LLC's Revocation of an Authorization Form.
4. This authorization is valid for 90-day period from the date it is signed, if an expiration date is not provided by me below.
5. A photocopy of fax of this Authorization Form is as valid as the original.
6. I understand that information uses or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
7. Jeffrey R. Zohner, M.D., LLC and his staff are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Name:__________________________Date:______________

Patient Signature (or Personal Representative):______________________
Relationship to Patient:______________________________

Expiration Date (If other than 90 days from date signed)________________

Revocation Date______________________________________