Barnes Jewish Hospital
Authorization For Release of Information
OR
Individual Accession to Information

I hereby authorize/request Barnes-Jewish Hospital to release/or grant me access to medical information of:

_____

(Patient's Full Name)

Former Name(s) (Where applicable): _____

Date of Birth: _____

I request only the following information to be released/accessed:

Patient's Name, Address, Room Number, Transplant Status:

_____ Pre-Transplant

_____ Post-Transplant – Date of Transplant _____

Release or Mail to:
1. Heart Transplant Association of St. Louis, P.O. Box 6115, Chesterfield, MO 63006
2. Pitter Patter, Inc., 514 Carson Road. St. Louis, MO 63135

For the purpose of: Informing the Heart Transplant Association (HTA) and Pitter Patter of the patient's condition and treatment so that the patient may be contacted by the HTA and Pitter Patter and receive further information concerning the HTA's/Pitter Patter services, publications and events.

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "confidential". I permit the release of all information indicated above including test results and / or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither BJC HealthCare nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting g treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I choose to do it.

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 one hundred eighty (180) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancer/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax or bring the letter to the addresses or fax numbers noted at the top of this page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate if the patient did not expire in the facility from which the information is requested.

NOTE: Records will be mailed to above address unless otherwise noted below.

_____ _____

Signature of Patient/Legal Guardian/Personal Representative Date

_____ _____

If someone else signs on behalf of the patient, state your Relationship to the Patient Date

_____ _____

Witness Date

Note:

If above address is not patient's, please complete the following:

Patient's Address: _____

Check if patient will pick up copies at [Facility] ☐

_____

Facility use only: Date Access/Request Granted: _____

Other Disposition (Date/Action): _____