BAER PEDIATRICS LLC

Jill Baer, M.D., Practice of Pediatrics, L.L.C.
Jill M. Baer, M.D., Kristen Mennemeier, M.D., &
Alicia Schumacher, M.D.
3009 N. Ballas Rd., Suite 257-C
St. Louis, MO 63131
Phone: 314-569-2112 Fax: 314-569-1270

RECORD RELEASE AUTHORIZATION

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMTION

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Information to be ***released*** (disclosed) by:

Information to be ***received*** (used) by:

The authorization permits the use or disclosure of the following individually identifiable health information, to be disclosed by the persons or entity named above on the LEFT, and received/used by the persons or entity named above and on the RIGHT. The following information is to be disclosed (specifically describe the information as to type, dates, origin of information, etc.) This information may include information on HIV/AIDS, mental/behavioral health, drug/alcohol abuse, and genetic testing.

Please identify the information to use, release, obtain or disclose (must you select at least one item):

- ☐ Please release my entire medical record

- ☐ Please release *only* the following information (check appropriate boxes and include other information where indicated):
- ☐ Lab results (Please describe the dates or types of lab tests you would like)
- ☐ Immunization Records
- ☐ Medication list
- ☐ Most recent history
- ☐ Other (please describe):_____

This authorization will expire on: _____

_____ _____ _____
Signature of Patient/Guardian Relationship Date

_____
Printed Name