AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ____(print name of patient, guardian or personal representative), hereby authorize St. Louis Record Center, LLC, on behalf of **Michael E. Beatty, M.D., F.A.C.S. or Southwestern Illinois Plastic & Hand Surgery**, to release my medical records to:

Person or entity: ____

Address: ____

Phone: __________________________________ Fax: ____

Purpose of Request: This Authorization is being completed at the request of the patient.

Information to be released: ____ Entire medical record _____ Specific portion(s) of medical record as described below:

____

____

____

I understand that when the information in my medical records is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA's Privacy Rule.

I understand that I may revoke this authorization at any time by a written document signed by me. I also understand that in the event that I do revoke this authorization, it will not have any effect on actions taken pursuant to this authorization prior to receipt of the revocation.

Neither treatment, payment, enrollment, nor eligibility for benefits, will be conditioned on my providing or refusing to provide this authorization.

I understand that I have a right to receive a copy of this authorization.

This authorization expires once the release of medical records requested herein is completed; and no more than ninety (90) days from the date this authorization is signed.

Signature of patient, guardian or personal representative: Relationship to patient:

____ ___________________________________

* Phone Number:___________________________________ Date:_______________________________

Description of Authority to Act for the Patient: ____

Please return this Authorization along with a clear copy of your driver's license or state identification to:

St. Louis Record Center (SLRC)
Attn: Sean Phelan
3728 Market Street, Suite 170
St. Louis, MO 63110

Phone: (314) 535-0016 Fax: (314) 535-0189

* St. Louis Record Center will call you with the amount due prior to sending copies

St. Louis Record Center Schedule of Copying Fees for Patients

(or Patient's Authorized Representative)

St. Louis Record Center charges the following fees for copying labor & supplies to patients or their authorized representatives, in accordance with Illinois Statutes [735 ILCS 5/8-2001(d)] and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(45 CFR 164.524). The below fees are the maximum allowable charges effective as of 1-20-2021 and are subject to change per Section 735 ILCS 5/8-2006 as of 1-20-2022 and every year thereafter on the same date:

$0.62 per page copying fee plus the cost of postage plus the cost of the envelope or box used for mailing the copies.

PLEASE NOTE: the above fees are the maximum allowable by law but it does not mean that your costs will include the above-listed fees. Please follow the steps below to determine your costs.

1) Please call St. Louis Record Center at (314) 535-0016 to verify the number of pages in your chart and to find the total cost of your request prior to payment.

2) Payment of copying fees is required in order to process your request.

3) St. Louis Record Center will mail your copies via USPS or you can pick them up at our facility.

St. Louis Record Center Schedule of Copying Fees for Third Party Requesters

The fees below will apply (as of January 20, 2021) per Illinois Code of Civil Procedure 735 ILCS 5/8-2001(d). These fees will be adjusted by statute each year on January 20.

Handling charge	$29.48
Copy pages 1 through 25	$1.11
Copy pages 26 through 50	$0.74
Copy pages in excess of 50	$0.37
Copies made from microfiche or microfilm	$1.84

St. Louis Record Center accepts checks, Mastercard, Visa or Money Orders.