Premier Medical Specialists

Timothy McCann, M.D.
3338 Watson Road
St. Louis, MO 63139
P: 314-647-0554
F: 314-647-8387

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby grant my permission for release of medical information relating to my case from and to the following parties:

From: Premier Medical Specialists
c/o: Timothy McCann, M.D.

To:_____

Address: _____

City/State/Zip Code:_____

Phone Number: _____

The purpose of this release of information is to provide continuity of care, for processing insurance claims or to meet another specific desire of mine. This information MAY include treatment for drug and/ alcohol abuse, psychiatric, psychological, HIV testing and/or AIDS treatment if they do occur. I specify that this release include:

_____ Entire Record

____ Other (Please specify) _____

_____

This authorization specifically pertains to information related to my treatment which occurred on:_____ to _____.

To assist in identification and location of my records, I am providing the following information used at the time of treatment:
Patient's name:_____

Date of birth: _____

Patient's address:_____

I understand that this authorization maybe withdrawn at any time in writing. This information will remain in effect for 90 days after I sign and date the form below. Recipients of my information are forbidden from re-disclosure without my specific authorization. A facsimile may be utilized with the same effectiveness as the original.

_____	_____	_____	_____
Patient Signature	Date	Witnessed by	Date
_____	_____		
Guardian or Legal Representative	Date		