ST. LOUIS COUNTY PRESCRIPTION DRUG MONITORING PROGRAM

Saint Louis COUNTY PUBLIC HEALTH

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI) FORM

INSTRUCTIONS

- Make an appointment to request records by contacting PDMP.DPH@stlouisco.com or 314-615-0522.
- Please fully complete the form below. This form must be submitted **in-person** at the address listed below.
  Saint Louis County Department of Public Health
  6121 N. Hanley Rd.
  Berkeley, MO 63134
- Requestors will need to provide their current driver's license or other valid government issued photo identification and sufficient proof of the authorization or delegation from the patient if you are requesting information on another person. Proof of authorization or delegation would include birth certificate, power of attorney, or advanced directive.
- For inquiries contact the PDMP Coordinator at PDMP.DPH@stlouisco.com or 314-615-0522.

PATIENT INFORMATION

Patient Name (first, middle, last):			
Requestor Name (if different than patient):			
Requestor Relationship to Patient:	☐ Self	☐ Parent/Guardian of Minor	☐ Power of Attorney
	☐ Personal Representative of Decedent		☐ Other:_____
Patient Date of Birth (mm/dd/yyyy):			
Street Address:			
City, State, Zip:		Phone Number:	
Request Date Range (mm/dd/yyyy):	to		

AUTHORIZATION TERMS

1. I authorize the use and disclosure of the above named individual's **controlled substance prescription history** to be ☐ obtained from or ☐ forwarded to the following individual or organization to make the disclosure:

   Recipient Name: _____

   Mailing Address: _____

   City, State, Zip: _____

2. Unless otherwise revoked, this authorization will expire on the following date _____.
   If I fail to specify an expiration date, this authorization will expire in ninety (90) days.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect of request copies of the health information to use or disclose as provided in 45 CFR 164.524. If I have any questions about disclosure of my health information, I can contact the Prescription Drug Monitoring Program (PDMP) Coordinator at PDMP.DPH@stlouisco.com or 314-615-0522.

4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy regulations.

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My signature below acknowledges that I have read, understand, and authorize release of my health information. My signature below certifies that I am or have been authorized to obtain PDMP data by the patient identified above.

_____ _____

Signature of Patient or Legal Representative Date (mm/dd/yyyy):

NOTICE OF REVOCATION

I, _____ hereby revoke my authorization of this disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

_____ _____

Signature of Patient or Legal Representative Date (mm/dd/yyyy):

INTERNAL USE ONLY:

Date Received: _____ ☐ Approved ☐ Denied

Issue Date: _____ Expiration Date: _____ Initials: _____