Premier Medical Specialists, LLC
Stella Maris Obesity Medicine
2315 Dougherty Ferry Road, Suite 109
St. Louis, MO 63122

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:

To:_____

From: Premier Medical Specialists, LLC
Stella Maris Obesity Medicine
2315 Dougherty Ferry Road, Suite 109
St. Louis, MO 63122
Phone: (314) 205-1926
Fax: (314) 984-2716

The purpose of this release of information is to provide continuity of care, for processing insurance claims or to meet any other specific desire of mine. This information MAY include treatment for drug and/or alcohol abuse, psychiatric or psychological conditions, 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 that occurred from: _____ 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I understand that this authorization may be withdrawn at any time in writing.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