



SAINT LOUIS INJURY AND REHABILITATION CENTER, LLC
8045 BIG BEND BLVD. SUITE 107 ST. LOUIS, MO 63119
PHONE: 314-961-7181 FAX: 314-961-6323

Health Care Authorization Form

Patient's Name _____

SSAN: _____ Date of Birth: _____

The patient identified above authorizes St. Louis Injury and Rehabilitation Center, LLC, (**SLIR**) to use and/or disclose protected health information in accordance with the following:

- I give permission to **SLIR** to use my address, phone number, and clinical records to contact me with appropriate reminders, missed appointment notices, birthday cards, holiday cards, and information related to treatment alternatives, or other health-related information.
- If **SLIR** contacts me by phone, I give them permission to leave a phone message on my answering machine or on voice mail.
- By signing this form, I am giving **SLIR** permission to use and disclose my protected information in accordance with the directives listed above.

Expiration

This authorization shall expire on: _____

Right to Revoke Authorization

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that **SLIR** has provided services or taken action in reliance on your authorization.

You may revoke this authorization my mailing or hand delivering a written notice to the Privacy Official of **SLIR**. The written notice must contain the following information:

Your name, social security number, birth date, a clear statement of your intent to revoke this authorization, the date of your request, and your signature.

The revocation is not effective until it is received by the Privacy Official.

This authorization is requested by **SLIR** for its own use/disclosure of personal health information.

You have the right to refuse to sign this authorization. If you refuse to sign this form, **SLIR** will not refuse to provide treatment.

You have the right to inspect or copy the personal health information to be used/disclosed.

A copy of this signed authorization will be provided to you.

Patient's Name (Print)

Patient's Signature

Date

Personnel Signature