Sandra S. Hoffmann, MD

Mandala Medical Services, LLC

RELEASE OF RECORDS FROM SANDRA S HOFFMANN, MD

INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

_____

Patient Name DOB Phone Number

_____

Street Address City, State Zip Code

RELEASE RECORDS TO: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

INFORMATION TO BE RELEASED:

- Clinical Records (last years worth OV notes and labs)
- Other (specify)
- _____

I understand that the specific information to be released may include, but not limited to: history, diagnosis, immunization record and/or treatment of drug or alcohol abuse, mental illness or communicable disease, including HIV/AIDS. I authorize the release of this specific data. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that the disclosure of information has been made prior to receipt of the revocation.

This authorization expires 90 days from the date of signature, unless I specify otherwise or revoke my authorization. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

I HAVE READ AND UNDERSTAND THIS CONSENT.

_____

Signature of Patient/Executor/Legal Representative Date

You may email scanned copy to SSHOFF@yahoo.com or mail to 5000 Cedar Plaza Pkwy Ste 220, Saint Louis, MO 63128

5000 Cedar Plaza Parkway
Suite 220
St. Louis, MO 63128
314-845-9010