SSM Health Cardinal Glennon Children's Hospital

PATIENT REQUEST TO BEGIN EVALUATION AND FINANCIAL CLEARANCE PROCESS AND RELEASE OF MEDICAL INFORMATION

I request that SSM Health Cardinal Glennon Children's Hospital begin the financial clearance process and transplant evaluation for my child or myself. I understand that our insurance company(ies) will be contacted in order to start this process. I authorize the physicians to release my child's or my medical records to SSM Health Cardinal Glennon Children's Hospital.

I authorize SSM Health Cardinal Glennon Children's Hospital to release any medical information pertaining to my child's or my diagnosis and /or treatment including but not limited to information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, medical history, treatment, or any other such related information to: 1) representative of local, state or federal agencies in accordance with law; 2) Medicare; 3) my insurance company or its designated representatives; 4) any person(s) or entities financially responsible for my care or treatment; 5) employees and representatives of SSM Health Cardinal Glennon Children's Hospital for investigation and defense of any claim or cause of action, actual or potential, which is our may be asserted against SSM Health Cardinal Glennon Children's Hospital, and/or any member of the medical and house staff at SSM Health Cardinal Glennon Children's Hospital and/or; 6) individual or entities for quality improvement, educational, medical research, accreditation or other purposes customarily utilized by the hospital and medical staffs in carrying out their functions. The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred at SSM Health Cardinal Glennon Children's Hospital. I further authorize release of this information to health care providers associated with my care outside SSM Health Cardinal Glennon Children's Hospital to facilitate further health care.

Patient Name (PLEASE PRINT): ____

Patient Signature: ____ Date: ____________________

IMPORTANT! This application must be filled out completely, signed and dated by you. Please attach a copy of all of your insurance cards to this application. If you have any questions regarding this application, please contact SSM Health Cardinal Glennon Children's Hospital Transplant Services office at 314-577-5351.

Please mail or fax application to: SSM Health Cardinal Glennon Children's Hospital
Transplant Services
1465 South Grand Blvd
St. Louis, MO 63104
Fax: 314-268-4151

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