Washington University Physicians®
Washington University School of Medicine in St. Louis

Authorization for Release of Health Record Information

I hereby authorize **Washington University Physicians** to transfer, release or obtain information on:

_____ _____ _____
(Name of Patient) (Date of Birth) (Last 4 digits of Social Security #)

OBTAIN FROM: (DO NOT LEAVE BLANK)

☐ Dr(s). _____

☐ Specialty _____
☐ All Washington University Physicians
☐ Non Washington University Physician
(Please complete section below)

_____
(Physician/Institution)

_____
(Address)

_____
(Address)

_____
(City, State, Zip)

_____ _____
(Phone) (Fax)

DISCLOSE TO: (DO NOT LEAVE BLANK)

_____
(Physician/Institution/Patient)

_____
(Attention)

_____
(Address)

_____
(Address)

_____
(City, State, Zip)

_____ _____
(Phone) (Fax)

_____
(E-mail address)

Select Delivery Method: ☐ E-Delivery ☐ Mail

For the purpose of:

- ☐ Continuing Medical Care
- ☐ Insurance
- ☐ School
- ☐ Military
- ☐ Legal Purposes
- ☐ Social Security/Disability
- ☐ Patient's Request
- ☐ Other (specify) _____

Date(s) of Treatment: ☐ Specific Dates: _____thru_____ ☐ All dates

Please Check Specific Information Requested

- ☐ All Records
- ☐ Abstract Record **(Office Notes, Procedures & Test Results Only)**
- ☐ Medication Records
- ☐ Laboratory/Pathology Reports
- ☐ Radiology Reports
- ☐ Verbal Communication Only **(No Records will be Released)**
- ☐ Office/Progress Notes
- ☐ Operative Report/Notes
- ☐ Discharge Summary
- ☐ Nurses Notes
- ☐ Other (specify) _____

Questions regarding Billing Records should be directed to Physician's Billing Services (Phone: 314-273-0763)
Questions regarding Radiology Films should be directed to the Radiology Film Library (Phone: 314-362-2850)

Psychotherapy Notes: This authorization does not include permission to release outpatient Psychotherapy Notes. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

Release of Psychotherapy Notes requires a separate authorization.

**** PLEASE ALLOW UP TO 30 DAYS FOR REQUEST TO BE PROCESSED. IF RECORDS ARE NEEDED SOONER, PLEASE CONTACT OUR OFFICE AT 314-273-0453. ****

I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment, or genetic counseling. I give my specific authorization for these records to be released.

☐ ____**Yes**, I consent to the release of this information Initial ☐ ____**No**, I do not consent to the release of this information Initial

- This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time by sending a written notice of revocation to:

  Washington University
  Health Information—Release Services
  Campus Box 1219
  4240 Duncan Ave., Suite 301
  St. Louis, MO 63110
  Office Phone: 314-273-0453 Fax: 844.868.1435

- The revocation will not apply to information already released in response to this authorization.
- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.
- I understand that once my information is used and/or disclosed pursuant to this authorization, it may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient(s).
- **I understand that a reasonable fee may be charged unless copies are sent to another physician or healthcare facility. This fee is based on the cost of the labor and supplies involved in copying the requested health information. Copies sent to other recipients (i.e. attorney, insurance companies) are subject to fees as provided by state law.**

Authorization is valid either for 90 days from the date of signature (if not otherwise specified) OR as specified by selecting one of these options:

☐ **This authorization expires on the following date _____**

☐ **This authorization expires due to the following event or special condition** _____

I have read and understand this consent and I have signed it voluntarily.

_____ _____
(Signature of Patient or Parent/Legal Representative) (Date)

_____
(Relationship to Patient-if not the patient)

_____ _____
(Witness) (Date)

_____ _____
(Patient's Address, City, State, Zip) (Patient's Phone)

(Certified copy of appointment of legal guardian or personal representative and death certificate of deceased patient must be attached)