Health Information Release Services-WUPI 660 South Euclid Ave., MSC 1219-35-3 St. Louis, MO 63110

Office: 314-273-0453 | Fax: 833-384-5921

Authorization for Release of Protected Health Information

I hereby authorize Washington University Physicians in Illinois, Inc. to transfer, release, or obtain information on: (Last 4 Digits of SSN) (Name of Patient) (Date of Birth) **OBTAIN FROM: (DO NOT LEAVE BLANK) DISCLOSE TO: (DO NOT LEAVE BLANK)** □ Dr(s). _____ (Physician/Institution/Patient) □ Specialty ☐ All Washington University Physicians in Illinois, Inc. (Attention) ☐ Non Washington University Physician (Please complete section below) (Address) (Physician/Institution) (Address) (Address) (City, State, Zip) (Address) (Fax) (Phone) (City, State, Zip) (E-mail address) Select Delivery Method: ☐ E-Delivery ☐ Mail (Phone) For the purpose of: ☐ Continuing Medical Care ☐ Legal Purposes ☐ Insurance ☐ Social Security/Disability ☐ School ☐ Patient's Request ☐ Military Other (specify) ☐ All dates Date(s) of Treatment: ☐ Specific Dates: _____thru____ Please Check Specific Information Requested ☐ All Records* ☐ Laboratory/Pathology Reports ☐ Office/Progress Notes ☐ Abstract Record (Office Notes, ☐ Radiology Reports ☐ Operative Note ☐ Verbal Communication Only ☐ Nurses Notes Procedures, Images, & Test Results Only) ☐ Itemized Billing Statements ☐ COVID-19 Saliva Test Results ☐ Medication Records (SARS-CoV-2) ☐ Other (specify) Questions regarding Billing Records should be directed to Physician's Billing Services (Phone: 314-273-0500 option 4) *Must check COVID-19 Saliva Test Results separately if those records are desired.

•	are not limited to: history, diagnosis, and/or treatment of HIV (AIDs virus), or alcohol abuse, mental illness, psychiatric treatment, or genetic counseling. Is to be released.
Initial	Genetic Testing Initial Mental Health/Developmental Disabilities Initial
written notice of revocation to: Washingto Health Info 660 South St. Louis, N	mation Release Services-WUPI uclid Ave., MSC 1219-35-3
 I understand that this authorization will be valid for 90 days from the date I sign it unless otherwise specified and that I can revoke it at any time. 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. 	
(Signature of Patient or Parent/Legal Representative	(Date)
(PRINT representative name if not the patient)	(Phone #)
(Relationship to patient)	
, -	tient/personal representative's identity is required for mental . HIV, and drug/alcohol records. Additionally, signature of patient is required for under the age of 18.)
(Witness Signature)	(Date)