Washington University School of Medicine in St. Louis

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

Office: 314.273.0453 | Fax: 844-868-1435

## **Authorization for Release of Protected Health Information**

lame of Patient)		(Date of Birth)			(Last 4 Digits of SSN)
OBTAIN FROM: (DO NOT LEAVE BLANK)	DISCLOSE T	DISCLOSE TO: (DO NOT LEAVE BLANK)			
□ Dr(s)		(Physician/Ins	itution/Patient)		
☐ Specialty					
☐ All Washington University Physicians		(Attention)			
☐ Non Washington University Physician					
(Please complete section below)		(Address)			
(Physician/Institution)		(Address)			
(Address)		(City, State, Zi	o)		
(Address)		(Phone)		(Fax)	
(City, State, Zip)		(E-mail addres	<u></u>		
(8)					
(Phone) (Fax)		Select Deliv	ery Method:	□ E-0	Delivery   Mail
For the purpose of:		-11-			
☐ Continuing Medical Care		☐ Legal	•		
☐ Insurance			Security/Disa	bility	
☐ School		☐ Patien	t's Request		
☐ Military					
☐ Other (specify)					
Date(s) of Treatment:		thru			All dates
Please Check Specific Information Requeste	d				
☐ All Records*		Laboratory/Patholog	gy Reports		Office/Progress Notes
☐ Abstract Record (Office Notes,		Radiology Reports			Operative Note
Procedures, Images, & Test		_			Nurses Notes
Results Only)		Itemized Billing Stat	ements		COVID-19 Saliva Test Results
<ul><li>☐ Medication Records</li><li>☐ Other (specify)</li></ul>					(SARS-CoV-2)

Questions regarding Radiology Films should be directed to the Radiology Film Library (Phone: 314-362-2850) \*Must check COVID-19 Saliva Test Results separately if those records are desired. **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. 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  $\square$  \_\_\_\_\_No, I do not consent to the release of this information Initial 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** 660 S Euclid Ave., MSC 1219-35-3 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 \_\_\_\_\_\_ (Signature of Patient or Parent/Legal Representative) (Date)

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

(Relationship to Patient-if not the patient)

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

(Witness)

(Date)

(Patient's Phone)