Washington University Physicians in Illinois INC.

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:

____________________ (Name of Patient)   __________ (Date of Birth)   __________ (Last 4 Digits of SSN)

OBTAIN FROM: (DO NOT LEAVE BLANK)

☐ Dr(s). ____________________

☐ Specialty ____________________
☐ All Washington University Physicians in Illinois, Inc.
☐ 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
☐ Other (specify) ____________________
☐ Legal Purposes
☐ Social Security/Disability
☐ Patient's Request

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

Please Check Specific Information Requested

☐ All Records*
☐ Abstract Record **(Office Notes, Procedures, Images, & Test Results Only)**
☐ Medication Records
☐ Other (specify) ____________________
☐ Laboratory/Pathology Reports
☐ Radiology Reports
☐ Verbal Communication Only
☐ Itemized Billing Statements
☐ Office/Progress Notes
☐ Operative Note
☐ Nurses Notes
☐ COVID-19 Saliva Test Results (SARS-CoV-2)

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.

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.

☐ ____ AIDS/HIV (Initial)

☐ ____Genetic Testing (Initial)

☐ ____Drug/Alcohol Use (Initial)

☐ ____Mental Health/Developmental Disabilities (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-WUPI
  660 S. Euclid Ave., MSC 1219-35-3
  St. Louis, MO 63110
  Office Phone: 314.273.0453 Fax: 833.384.5921

- 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)

*(Signature of a witness who has verified the patient/personal representative's identity is required for mental health/developmental disability, genetic testing, HIV, and drug/alcohol records. Additionally, signature of patient is required for mental health records if over the age of 12 and under the age of 18.)

____ ______________________

(Witness Signature) (Date)