



REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION BY INDIVIDUAL PATIENTS

Please check (✓) the appropriate box(es) (☐) and fill in the blank(s) as needed.

Individual Patient Name: _____

Patient's Date of Birth: _____ Last 4 of SSN: _____

Home Phone Number: _____ Cell Phone Number: _____

Dr(s). _____ Specialty: _____

All Washington University Physicians

Please Check Specific Information Requested

- | | | |
|--|--|---|
| <input type="checkbox"/> All Records* | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Operative Note |
| <input type="checkbox"/> Abstract of record (Office Notes, Procedures, & Test Results Only) | <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> Other Procedure Report |
| <input type="checkbox"/> Images/Videos/Recordings | <input type="checkbox"/> Nuclear Medicine Report | <input type="checkbox"/> Radiology (X-ray) reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Itemized Billing Statement |
| <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> Pathology Reports | |
| | <input type="checkbox"/> COVID-19 Saliva Test Results (SARS-CoV-2) | |

Requests for Billing Records should be sent to Physician's Billing Services (Phone: 314-273-0500 option 4)

Requests for Radiology Films should be sent to the Radiology Film Library (Phone: 314-362-2850)

*Must check COVID-19 Saliva Test Results separately if those records are desired.

Date(s) of Treatment: Specific Dates: _____ thru _____ All dates

In what format would you like to receive your records: Paper Copy Electronic Copy

Release or Mail To:

Individual/Legal Guardian/Personal Representative: _____

Mailing Address: _____

City, State, Zip Code: _____

Phone Number of Individual Receiving Records: _____

Email Address: _____

Email is not a secure means of communication. We will encrypt email communications of your records unless you tell us you prefer us to use unencrypted email. If you prefer we not encrypt our communications to you, please initial here: _____

Processing Your Requested Information:

Washington University Physicians may charge a fee for the copying of requested health information plus postage for mailing the copies to you. If you would like a copy of your record to be provided on portable media such as a CD or USB drive, we may charge you the actual cost of the portable media.

Washington University Physicians will respond to your request for health information within 30 days of our receipt of your request. If, however, your health information is not readily accessible by Washington University Physicians or is maintained in an off-site storage location, Washington University Physicians has an additional 30 days to respond to your request. If we require additional time to respond to your request, we will contact you to inform you of this extension of time.

We appreciate your patience while we process your request.

Signature of Patient/Legal Guardian/Personal Representative

Date