



# Washington University Physicians®

## 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

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

\_\_\_\_\_  
(Name of Patient)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Last 4 Digits of SSN)

<p><b>OBTAIN FROM: (DO NOT LEAVE BLANK)</b></p> <p><input type="checkbox"/> Dr(s). _____</p> <p><input type="checkbox"/> Specialty _____</p> <p><input type="checkbox"/> All Washington University Physicians</p> <p><input type="checkbox"/> Non Washington University Physician <b>(Please complete section below)</b></p> <p>_____ (Physician/Institution)</p> <p>_____ (Address)</p> <p>_____ (Address)</p> <p>_____ (City, State, Zip)</p> <p>_____ (Phone)          _____ (Fax)</p>	<p><b>DISCLOSE TO: (DO NOT LEAVE BLANK)</b></p> <p>_____ (Physician/Institution/Patient)</p> <p>_____ (Attention)</p> <p>_____ (Address)</p> <p>_____ (Address)</p> <p>_____ (City, State, Zip)</p> <p>_____ (Phone)          _____ (Fax)</p> <p>_____ (E-mail address)</p> <p>Select Delivery Method:    <input type="checkbox"/> E-Delivery    <input type="checkbox"/> Mail</p>										
<p><b>For the purpose of:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Continuing Medical Care</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Legal Purposes</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Insurance</td> <td style="border: none;"><input type="checkbox"/> Social Security/Disability</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> School</td> <td style="border: none;"><input type="checkbox"/> Patient's Request</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Military</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Other (specify) _____</td> <td style="border: none;">_____</td> </tr> </table>		<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Legal Purposes	<input type="checkbox"/> Insurance	<input type="checkbox"/> Social Security/Disability	<input type="checkbox"/> School	<input type="checkbox"/> Patient's Request	<input type="checkbox"/> Military	_____	<input type="checkbox"/> Other (specify) _____	_____
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<input type="checkbox"/> Military	_____										
<input type="checkbox"/> Other (specify) _____	_____										

**Date(s) of Treatment:**    Specific Dates: \_\_\_\_\_ thru \_\_\_\_\_

All dates

Please Check Specific Information Requested		
<input type="checkbox"/> All Records* <input type="checkbox"/> Abstract Record ( <b>Office Notes, Procedures, Images, &amp; Test Results Only</b> ) <input type="checkbox"/> Medication Records <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Laboratory/Pathology Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Verbal Communication Only <input type="checkbox"/> Itemized Billing Statements	<input type="checkbox"/> Office/Progress Notes <input type="checkbox"/> Operative Note <input type="checkbox"/> Nurses Notes <input type="checkbox"/> COVID-19 Saliva Test Results (SARS-CoV-2)
<p>Questions regarding Billing Records should be directed to Physician's Billing Services (Phone: 314-273-0500 option4)</p>		

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            **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:

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- 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)

\_\_\_\_\_  
(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.