Washington University Physicians®
Washington University School of Medicine in St. Louis

Health Information Release Services
Campus Box 1219 | Suite 301
4240 Duncan Ave.
St. Louis, MO 63110
Office Phone: 314.273.0453

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

(Name of Patient) _____ (Date of Birth) _____ (Last 4 digits of Social Security #) _____

OBTAIN FROM:	DISCLOSE TO:
(Physician/Institution)	Washington Univ School of Medicine (Physician/Institution/Patient)
(Attention)	Attn: DESSH Clinic (Savannah Fisher) (Address)
(Address)	660 S Euclid Avenue, CB 8116 (Address)
(Address)	St. Louis, MO 63110 (City, State, Zip)
(City, State, Zip)	314-747-0791 (Phone) 314-286-0036 (Fax)
(Phone) (Fax)	pedsdesshclinic@wustl.edu (E-mail address for electronic delivery of records)

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
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Pathology
- ☐ Medication Records
- ☐ Laboratory Reports
- ☐ X-Ray Reports
- ☐ Emergency Room Report
- ☐ Nurses Notes
- ☐ Nuclear Medicine Report
- ☐ Progress Notes
- ☐ Operative Report
- ☐ Operative Notes
- ☐ Endoscopy
- ☐ Other (specify) _____

Requests for Billing Records should be sent to Physician's Billing Services (Phone: 314-273-0763)
Requests for Radiology Films should be sent to the Radiology Film Library (Phone: 314-362-2850)

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 Initial ☐ ____**No,** I do not consent to the release of this information 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:
  Health Information—Release Services
  Campus Box 1219
  4240 Duncan Ave., Suite 301
  St. Louis, MO 63110
  Office Phone: 314-273-0453 Fax: 888-965-5131
  Email: hirs@wusm.wustl.edu
- 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. There is a $0.54 charge per page (plus postage) for personal copies of your record. 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** _____

I have read and understand this consent and I have signed it voluntarily.

_____ _____
(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)

Revised: 5/14