Washington University in St. Louis
SCHOOL OF MEDICINE

Office of Student Health Services
660 South Euclid Ave., CB 8030
St. Louis, MO 63110
Phone: 314.362.3523|Fax: 314.362.0058

I hereby authorize **Washington University School of Medicine, Student Health Services,** to transfer, release or obtain information on:

_____ _____ _____
(Name of Patient) (Date of Birth) (Last 4 Digits of SSN)

OBTAIN FROM:

☐ **Student Health Services**

_____
(Physician)

660 South Euclid Ave., Campus Box 8030
St Louis, MO 63110
Phone: (314) 362-3523
Fax: (314) 362-0058

☐ **Non Washington University Physician**

_____
(Physician/Institution)

_____
(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)**
☐ Other (specify) _____
☐ Laboratory/Pathology Reports
☐ Medication Records
☐ Immunizations
☐ Office/Progress Notes
☐ Nurses Notes

Questions regarding Billing Records should be directed to Physician's Billing Services(Phone: 314-273-0763)

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), 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.

- ☐ ____ **Mental Health/Developmental Disabilities diagnosis and treatment**
  Initial
- ☐ ____ **Drug/Alcohol Use diagnosis and treatment**
  Initial
- ☐ ____ **HIV/STD testing and treatment**
  Initial
- ☐ ____ **Genetic testing**
  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:

  Office of Student Health Services
  660 South Euclid Ave., Campus Box 8030
  St. Louis, MO 63110
  Office Phone: (314) 362-3523
  Fax: (314) 362-0058

- 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 for 90 days from the date of signature (if not otherwise specified)

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Parent/Legal Representative) (Date)

_____
(Relationship to Patient-if not the patient)

_____ _____
(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)