Washington University in St. Louis
Physicians

AUTHORIZATION FOR RELEASE OF RECORDS

PLEASE HAVE YOUR PHYSICIAN MAIL/FAX RECORDS TO:

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

_____ _____ ___-___-____
(Name of Patient) (Date of Birth) (Social Security Number)

OBTAIN FROM:

_____
(Physician/Institution)

_____
(Attention)
(Address)

_____
(City, State Zip)

_____
(Phone) (Fax)

SEND OR FAX RECORDS TO:

_____

St. Louis Children's Hospital
Suite 4S30, Box 8116
One Children's Place
St. Louis, MO 63110

314-454-6093 (Phone)
314-454-2075 (Fax)

For the purpose of:

_____

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

Please Check Specific Information Requested

_____All Records	_____Laboratory Reports	_____ Progress Notes
_____ Discharge Summary	_____X-ray Reports	_____ Operative Report
_____ History & Physical	_____Emergency Room Report	_____ Operative Notes
_____Pathology	_____ Nurses Notes	_____ Endoscopy
_____Medication Records	_____ Nuclear Medicine Reports	_____

_____Other (Please Specify)

I understand that my records may contain but is not limited to: history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time to the extent that prior action has not been taken on this authorization. I also understand that my revocation of this authorization must be in writing. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Authorization is valid for 90 days from the date of signature unless revoked in writing.
I have read and understand this consent and I have signed it voluntary.

_____ _____ _____
(Signature of patient or Parent/Legal Representative) (Relationship to Patient) (Date)

_____ _____
(Witness) (Date)

_____ _____
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 1/12/05