Washington University in St. Louis
Physicians

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) (Social Security Number)

OBTAIN FROM:

(Physician/Institution)

(Attention)

(Address)

(City, State, Zip)

(Phone) (Fax)

SEND OR FAX TO:

Washington University School of Medicine

Attn: Desi Freeman

425 S. Euclid Ave

MSC 8024-14-4711

Saint Louis, MO 63110

314-747-3562 (Phone) 314-747-7336 (Fax)

For the purpose of:
Clinical Laboratory Testing requested by a treating physician

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

Please Check Specific Information Requested

Discharge Summary	Laboratory Reports	All Records
History & Physical	X-ray Reports	Progress Notes
Endoscopy	Emergency Room Report	Operative Report
X Pathology Reports	Nurses Notes	Operative Notes
Medication Records	Nuclear Medicine Reports	

X Surgical Pathology Paraffin Embedded Block(s) & associated H&E slides Other (Please Specify)

Other (Please Specify)

I understand that my records may contain information regarding the diagnosis 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 been taken on this authorization. I also understand that my revocation of this authorization must be in writing.

Authorization is valid for 90 days from the date of signature.

(Signature of patient or legal representative) (Date)

(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)