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: Tracey Hammontree
425 S. Euclid Ave
Campus Box 8024
Saint Louis, MO 63110
314-747-3562 314-747-7336
(Phone) (Fax)

For the purpose of:
Clinical Laboratory Testing to aid in Cancer Detection and Treatment Decisions

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)