



Washington University Physicians

Washington University School of Medicine in St. Louis

Authorization for Release of Health Record Information

I hereby authorize Washington University Clinical Associates – Northwest Pediatrics, LLC to transfer, release or obtain information on:

(Name of Patient)

(Date of Birth)

(Social Security Number)

<p>OBTAIN FROM:</p> <p>_____ (Physician/Institution)</p> <p>_____ (Attention)</p> <p>_____ (Address)</p> <p>_____ (Address)</p> <p>_____ (City, State, Zip)</p> <p>_____ (Phone) _____ (Fax)</p>	<p>DISCLOSE TO:</p> <p>_____ (Physician/Institution)</p> <p>_____ (Attention)</p> <p>_____ (Address)</p> <p>_____ (Address)</p> <p>_____ (City, State, Zip)</p> <p>_____ (Phone) _____ (Fax)</p>		
<p>For the purpose of:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> School <input type="checkbox"/> Military <input type="checkbox"/> Other (specify) _____ </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Social Security/Disability <input type="checkbox"/> Patient's Request </td> </tr> </table>		<input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> School <input type="checkbox"/> Military <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Legal Purposes <input type="checkbox"/> Social Security/Disability <input type="checkbox"/> Patient's Request
<input type="checkbox"/> Continuing Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> School <input type="checkbox"/> Military <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Legal Purposes <input type="checkbox"/> Social Security/Disability <input type="checkbox"/> Patient's Request		

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

Please Check Specific Information Requested		
<input type="checkbox"/> All Records <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Pathology <input type="checkbox"/> Medication Records <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Laboratory Reports <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Emergency Room Report <input type="checkbox"/> Nurses Notes <input type="checkbox"/> Nuclear Medicine Report	<input type="checkbox"/> Progress Notes <input type="checkbox"/> Operative Report <input type="checkbox"/> Operative Notes <input type="checkbox"/> Endoscopy <input type="checkbox"/> Billing Information (to be released by PBS)
<p>Note: This authorization does not allow release of radiology films or pathology slides</p>		

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.

