



AUTHORIZATION FOR RELEASE OF RECORDS

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

(Name of Patient) (Date of Birth) (Social Security Number)

OBTAIN FROM:

SEND OR FAX TO:

(Physician/Institution)

Bryan F. Meyers, MD, MPH

(Physician/Institution)

(Attention)

Mary

(Attention)

(Address)

660 South Euclid Avenue

(Address)

Campus Box 8234

(City, State, Zip)

St. Louis, MO 63110

(City, State Zip)

(Phone)

(Fax)

(314) 362-8598

(Phone)

(314) 362-0328

(Fax)

For the purpose of:

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

(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)