



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)

 (Attention)

 (Address)

Dr. Traves Crabtree

 (Physician/Institution)
Kathy Atwater

 (Attention)
660 South Euclid, Campus Box 8234

 (Address)

 (City, State, Zip)

 (Phone) (Fax)

St. Louis, MO 63110

 (City, State Zip)
314-362-8089 314-747-4109

 (Phone) (Fax)

For the purpose of:

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

Please Check Specific Information Requested

- | | | |
|--------------------------|--------------------------------|----------------------------|
| _____ All Records | _____ Laboratory Reports | _____ Chest CT films/CD |
| _____ Discharge Summary | _____ X-ray Reports | _____ Operative Report |
| _____ History & Physical | _____ Emergency Room Report | _____ Operative Notes |
| _____ Pathology slides | _____ Nurses Notes | _____ Endoscopy Report |
| _____ Medication Records | _____ Nuclear Medicine Reports | _____ Chest x-ray films/CD |

_____ 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 voluntarily.**

 (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)