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 – Blue Fish, LLC to transfer, release or obtain information on:

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

OBTAIN FROM:	**DISCLOSE TO:**
_____ (Physician/Institution)	_____ (Physician/Institution)
_____ (Attention)	_____ (Attention)
_____ (Address)	_____ (Address)
_____ (Address)	_____ (Address)
_____ (City, State, Zip)	_____ (City, State, Zip)
_____ (Phone) _____ (Fax)	_____ (Phone) _____ (Fax)

For the purpose of:

- ☐ Continuing Medical Care
- ☐ Insurance
- ☐ School
- ☐ Military
- ☐ Other (specify) _____
- ☐ Legal Purposes
- ☐ Social Security/Disability
- ☐ Patient's Request

Date(s) of Treatment: ☐ Specific Dates:_____thru_____ ☐ All dates

Please Check Specific Information Requested

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

☐ Other (specify) _____

Requests for Billing Records should be sent to Physician's Billing Services (Phone: 314-273-0763)

Note: This authorization does not allow release of radiology films or pathology slides

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.

I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

☐ ____**Yes**, I consent to the release of this information Initial ☐ ____**No**, I do not consent to the release of this information Initial

- This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time by sending a written notice of revocation to:

  WUCA - Blue Fish, LLC
  12360 Manchester Road
  Suite 100
  St. Louis, MO 63131
  Office: (314) 966-8500
  Fax: (314) 966-4499
- The revocation will not apply to information already released in response to this authorization.
- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.
- I understand that once my information is used and/or disclosed pursuant to this authorization, it may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient(s).
- I understand that a reasonable fee may be charged.

Authorization is valid either for 90 days from the date of signature (if not otherwise specified) OR as specified by selecting one of these options:

☐ **This authorization expires on the following date _____**

☐ **This authorization expires due to the following event or special condition** _____

I have read and understand this consent and I have signed it voluntarily.

_____ _____
(Signature of patient or Parent/Legal Representative) (Date)

_____
(Relationship to Patient)

_____ _____
(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)

Revised: 9/11/2012