AUTHORIZATION for DISCLOSURE

SAINT LOUIS UNIVERSITY. EST. 1818

SLUCare® Physician Group

Health Information Management
Center for Specialized Medicine
1225 South Grand Blvd Garden Level
St. Louis Mo 63104-1016
314-977-6017

I authorize Saint Louis University/SLUCare to release the following information

Patient's Name / Previous Names:

_____

_____

Birth Date Social Security Number Medical Record #

RECIPIENT **(person or organization that will receive your information)**

_____

(Doctor / Hospital / Attorney / Insurance Company / Self / etc.)

_____

Address (Street, City, State, ZIP code) Phone Number

FORMAT: ☐ Paper ☐ Electronic (CD) ☐ MyChart (Requests to Self Only)

DESCRIPTION of INFORMATION to be RELEASED

Check items that apply:

☐ Psychotherapy notes **If you check this box, you may not check another box below.**

Federal law requires a separate authorization to use or release psychotherapy notes.

☐ All SLU*Care* Records

☐ All Records (*including outside provider records*)

Specific Information Only *(May list specific incident or identify body region)*

- ☐ Summary of Medical History/Treatment
- ☐ Laboratory / Diagnostic Tests
- ☐ Immunization Records
- ☐ Pathology Reports(s) (SLU*Care*)
- ☐ Radiology Reports
- ☐ Operative Report (SLU*Care*)
- ☐ Progress Note
- ☐ Psychological Testing
- ☐ After Visit Summary
- ☐ EKG Report
- ☐ EEG Report
- ☐ Genetic Testing
- ☐ Billing Information
- ☐ Other_____

_____

Outpatient, Date(s) of Service: _____

Records from Specific Provider(s) _____

Body Region / Incident _____

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

PURPOSE of DISCLOSURE

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

I understand that the specific information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including human immunodeficiency virus, (HIV) and acquired immune deficiency syndrome (AIDS), or specific information which requires release by a minor. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice.

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that fees may be associated with this request for medical information.

EXPIRATION (Dates of service after signature date will not be released)

This authorization expires on the following date, event, or special condition.

_____

(*If no expiration is provided, this authorization will expire in one year.)*

APPROVAL **(You or your Personal Representative must sign and date this form for completion.)**

Patient:

_____
(Print Name)

_____
(Signature)

_____
(Date)

Patient Representative: The person who has legal authority to act on behalf of the individual. A copy of a Healthcare Power of Attorney or other legal document must be on file or submitted with this form.

_____
(Printed Name of Personal Representative)

_____
(Signature of Personal Representative)

_____ _____
(Date) (Description of Authority)

NOTICE OF REVOCATION

I _____, hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Patient _____ Date _____

Personal Representative _____ Date _____