# AUTHORIZATION for DISCLOSURE

SAINT LOUIS UNIVERSITY

**SLU*Care***

**The Physicians of Saint Louis University**

**Health Information Management**
Correspondence Division
West Pavilion, Ground Floor
3655 Vista Ave
St Louis, MO 63110
314-268-7012

**I authorize Saint Louis University/SLU*Care* 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

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 _____