



Washington University Physicians®

Washington University School of Medicine in St. Louis

Health Information Release Services
660 South Euclid Ave., Campus Box 1219
Cancer Research Building Room: 112
St. Louis, MO 63110
Office: 314.273.0453 | Fax: 844-868-1435
Email: hirs@wustl.edu

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

(Name of Patient)

(Date of Birth)

(Last 4 Digits of SSN)

<p>OBTAIN FROM: (DO NOT LEAVE BLANK)</p> <p><input type="checkbox"/> Dr(s). _____</p> <p><input type="checkbox"/> Specialty _____</p> <p><input type="checkbox"/> All Washington University Physicians <input type="checkbox"/> Non Washington University Physician (Please complete section below)</p> <p>_____ (Physician/Institution)</p> <p>_____ (Address)</p> <p>_____ (Address)</p> <p>_____ (City, State, Zip)</p> <p>_____ (Phone) _____ (Fax)</p>	<p>DISCLOSE TO: (DO NOT LEAVE BLANK)</p> <p>_____ (Physician/Institution/Patient)</p> <p>_____ (Attention)</p> <p>_____ (Address)</p> <p>_____ (Address)</p> <p>_____ (City, State, Zip)</p> <p>_____ (Phone) _____ (Fax)</p> <p>_____ (E-mail address)</p> <p>Select Delivery Method: <input type="checkbox"/> E-Delivery <input type="checkbox"/> Mail</p>
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For the purpose of:

<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Legal Purposes
<input type="checkbox"/> Insurance	<input type="checkbox"/> Social Security/Disability
<input type="checkbox"/> School	<input type="checkbox"/> Patient's Request
<input type="checkbox"/> Military	
<input type="checkbox"/> Other (specify) _____	

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

Please Check Specific Information Requested

<input type="checkbox"/> All Records	<input type="checkbox"/> Laboratory/Pathology Reports	<input type="checkbox"/> Office/Progress Notes
<input type="checkbox"/> Abstract Record (Office Notes, Procedures, Images, & Test Results Only)	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Operative Report/Notes
<input type="checkbox"/> Medication Records	<input type="checkbox"/> Verbal Communication Only	<input type="checkbox"/> Nurses Notes
<input type="checkbox"/> Other (specify) _____		

Questions regarding Billing Records should be directed to Physician's Billing Services (Phone: 314-273-0763)
Questions regarding Radiology Films should be directed to the Radiology Film Library (Phone: 314-362-2850)

