Washington University Physicians®
Washington University School of Medicine in St. Louis

Authorization for Release of Protected Health Information

(Name of Patient) | (Date of Birth) | (Social Security Number)

OBTAIN FROM:

(Physician/Institution)

(Attention)

(Address)

(City) | (State) | (Zip)

(Phone) | (Fax)

SEND OR FAX TO:

Washinton University School of Medicine

(Physician/Institution)

(Attention)

425 S. Euclid Ave.

(Address)

Campus Box 8024

Saint Louis | MO | 63110

(City) | (State) | (Zip)

(Phone) | (Fax)

Purpose: Clinical laboratory testing to aid in cancer detection and treatment decisions

Dates of Treatment _____ (All dates) _____ (Specific dates) thru _____

Specific Information Requested (check all that apply)

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

☒ Other (specify): Surgical pathology paraffin embedded blocks(s) & associated H&E slides

☐ Other (specify): _____

Authorization is valid for 90 days from the date of signature.

I understand that my records may contain information regarding the diagnosis 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 been taken on this authorization. I also understand that my revocation of this authorization must be in writing.

Signature of patient or legal representative(s) | 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.