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

# Authorization for Release of Health Record Information

I hereby authorize **Purely Pediatrics, LLC** to transfer, release or obtain information on:

_____ _____ _____
(Name of Patient) (Date of Birth) (Last 4 digits of Social Security #)

| **OBTAIN FROM: (DO NOT LEAVE BLANK)** | **DISCLOSE TO: (DO NOT LEAVE BLANK)** |
|---|---|
| ☐ Dr(s). _____ | Purely Pediatrics<br>(Physician/Institution/Patient) |
| ☐ Specialty _____<br>☐ Non Washington University Physician<br>**(Please complete section below)** | _____<br>(Attention) |
| _____<br>(Physician/Institution) | 13001 N. Outer Forty<br>(Address) |
| _____<br>(Address) | Suite 330<br>(Address) |
| _____<br>(Address) | Town & Country, MO 63017<br>(City, State, Zip) |
| _____<br>(City, State, Zip) | 314-454-5500 (Phone) 314-454-5501 (Fax) |
| _____ (Phone) _____ (Fax) | _____<br>(E-mail address) |
| | Select Delivery Method: ☐ E-Delivery ☐ Mail |

**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
- ☐ Abstract Record **(Office Notes, Procedures & Test Results Only)**
- ☐ Medication Records
- ☐ Other (specify) _____
- ☐ Laboratory/Pathology Reports
- ☐ Radiology Reports
- ☐ Verbal Communication Only **(No Records will be Released)**
- ☐ Office/Progress Notes
- ☐ Operative Report/Notes
- ☐ Discharge Summary
- ☐ Nurses Notes

Questions regarding WU Radiology Films should be directed to the Radiology Film Library (Phone: 314-362-2850)

**Psychotherapy Notes:** This authorization does not include permission to release outpatient Psychotherapy Notes.

**** PLEASE ALLOW UP TO 30 DAYS FOR REQUEST TO BE PROCESSED. IF RECORDS ARE NEEDED SOONER, PLEASE CONTACT OUR OFFICE AT 314-454-5500. ****

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, psychiatric treatment, or genetic counseling. 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:

  **Purely Pediatrics, LLC**
  **13001 N. Outer Forty**
  **Suite 330**
  **Town & Country, MO 63017**
  **Office Phone: 314-454-5500 Fax: 314-454-5501**

- 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. Copies sent to other recipients (i.e. attorney, insurance companies) are subject to fees as provided by state law.**

**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-if not the 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)**