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

Authorization for Release of Health Record Information

I hereby authorize Washington University Clinical Associates – Cloverleaf Pediatrics, LLC to transfer, release or obtain information on:

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

OBTAIN FROM:	**DISCLOSE TO:**
_____ (Physician/Institution)	**WUCA-Cloverleaf Pediatrics, LLC** (Physician/Institution/Patient)
_____ (Attention)	**5301 Veterans Memorial Parkway** (Address)
_____ (Address)	**Ste. 104** (Address)
_____ (Address)	**St. Peter, MO 63376** (City, State, Zip)
_____ (City, State, Zip)	**(636) 939-3362** (Phone) **(636) 939-3687** (Fax)
_____ (Phone) _____ (Fax)	***Please do not fax records over 35 pages***

For the purpose of:

- X 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

Specific Information Requested: **Immunization Record**
Growth Charts
Medications Record
Problem List

Please fax these specific records to (636) 939-3687 as soon as possible. Thank you.

Other Information requested (please check only if **our office requests the additional information**)

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Pathology
- ☐ Other (specify) _____
- ☐ Laboratory Reports
- ☐ X-Ray Reports
- ☐ Emergency Room Report
- ☐ Nurses Notes
- ☐ Nuclear Medicine Report
- ☐ Progress Notes
- ☐ Operative Report
- ☐ Operative Notes
- ☐ Endoscopy

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

  WUCA – Cloverleaf Pediatrics, LLC
  5301 Veterans Memorial Pkwy
  Suite 104
  St. Peters, MO 63376
  Office: (636) 939-3362
  Fax: (636) 939-3687
- 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 unless copies are sent to another physician or healthcare facility. There is a $0.54 charge per page (plus postage) for personal copies of your record. 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)

Revised: 5/14