SAINT LOUIS UNIVERSITY
STUDENT HEALTH CENTER

Marchetti Towers East
3518 Laclede Ave
St. Louis, MO 63103
P: 314-977-2323
F: 314-977-7165

AUTHORIZATION for DISCLOSURE

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 / Family Member etc.)

_____
Address (Street, City, State, ZIP code) Phone Number Fax Number

☐ I would like my records sent to MyChart * ☐ I would like records copied to a CD*

*Please note these options are for patient records in EPIC only and do not include any records from banner.

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 Records (not including psychotherapy notes)

Please note that while psychiatry records from the Student Health Center are processed via this form, counseling records are processed through the University Counseling Center. You can reach them at 314-977-8255.

Specific Information Only *(May list specific incident or identify body region)*

- ☐ Summary of Medical History/Treatment
- ☐ Laboratory / Diagnostic Tests
- ☐ Immunization Records
- ☐ Pathology Reports(s)
- ☐ Radiology Reports(s)
- ☐ Operative Report
- ☐ Progress Note
- ☐ 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 m y 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 _____