



AUTHORIZATION for DISCLOSURE

I authorize Saint Louis University/ SLUCare 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 prefer my records be RELEASED OR ONLY INFORMATION

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 | After Visit Summary |
| Laboratory / Diagnostic Tests | EKG Report |
| Immunization Records | EEG Report |
| Pathology Reports(s) | Genetic Testing |
| Radiology Reports(s) | Billing Information |
| Operative Report | Other _____ |
| Progress Note | |

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.

