

AUTHORIZATION for DISCLOSURE



**SLUCare**

The Physicians of  
Saint Louis University

Health Information Management  
Correspondence Division  
West Pavilion, Ground Floor  
3655 Vista Ave  
St Louis, MO 63110  
314-268-7012

**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)**

Hoosier Services Inc.

(Doctor / Hospital / Attorney / Insurance Company / Self / etc.)

18032 Lemon Drive, Suite C-618, Yorba Linda, CA 92886

800.882.4156

Address (Street, City, State, ZIP code)

Phone Number

**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 SLUCare Records
- All Records (including outside provider records)

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

- |   |  |
|---|--|
| <input type="checkbox"/> Summary of Medical History/Treatment | <input type="checkbox"/> After Visit Summary |
| <input type="checkbox"/> Laboratory / Diagnostic Tests        | <input type="checkbox"/> EKG Report          |
| <input type="checkbox"/> Immunization Records                 | <input type="checkbox"/> EEG Report          |
| <input type="checkbox"/> Pathology Reports(s) (SLUCare)       | <input type="checkbox"/> Genetic Testing     |
| <input type="checkbox"/> Radiology Reports                    | <input type="checkbox"/> Billing Information |
| <input type="checkbox"/> Operative Report (SLUCare)           | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Progress Note                        | _____  |
| <input type="checkbox"/> Psychological Testing                | _____  |

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) Life Insurance
- 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 my 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 \_\_\_\_\_