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 myself

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.