Washington University School of Medicine in St. Louis

Health Information Release Services Campus Box 1219 | Suite 301 4240 Duncan Ave. St. Louis, MO 63110

Office Phone: 314.273.0453

(Name of Patient)			(Date of Birth)	(Last 4 digits of Social Security #	
OBTAIN FROM:		DISCLOSE TO:			
			Marwan Shinawi, N	M.D	
(Physician/Institution)			(Physician/Institution/Patien	(Physician/Institution/Patient)	
			Washington Universi	ty School of Medicine	
(Attention)			(Address)		
			660 S. Euclid Avenue	e. Campus Box 8116	
(Address)			(Address)		
			St. Louis, MO 63110		
(Address)			(City, State, Zip)		
			314-454-6093	844-965-9624	
(City, State, Zip)			(Phone)	(Fax)	
			mshinawi@wustl.e	edu	
(Phone)	hone) (Fax)		(E-mail address for electronic	(E-mail address for electronic delivery of records)	
For the purpose of					
	g Medical Care		☐ Legal Purposes	☐ Legal Purposes ☐ Social Security/Disability	
	☐ Insurance			☐ Patient's Request	
☐ Military			= rutient s nequest	•	
☐ Other (sp	ecify)				
_					
Date(s) of Treatment: ☐ Specific Dates:			thru	☐ All dates	
.,	•				
Please Check Snec	fic Information Re	huested			
✓ All Record		•	Laboratory Reports	☐ Progress Notes	
,	Summary		X-Ray Reports	☐ Operative Report	
☐ History &	•		Emergency Room Report	☐ Operative Notes	
□ Pathology			Nurses Notes	☐ Endoscopy	
☐ Medication	n Records		Nuclear Medicine Report		
	ecify) Inclu	ıdina a	Il genetic results		

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, diagn other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, counseling. I give my specific authorization for these records to be released.	· · · · · · · · · · · · · · · · · · ·					
✓Yes, I consent to the release of this information ☐No, I do not Initial	consent to the release of this information					
This request is a free and voluntary act by me. I understand that I may revoke a written notice of revocation to: Health Information—Release Servi Campus Box 1219 4240 Duncan Ave., Suite 301 St. Louis, MO 63110 Office Phone: 314-273-0453 Fair Email: hirs@wusm.wustl.edu The revocation will not apply to information already released in response to the suit of the property of the response to the suit of the property	ces x: 888-965-5131					
 I understand that if I choose not to give this permission or if I cancel my perm treatment or benefits that I am entitled to, as long as this information is not a services or to pay for the services that I receive. I understand that once my information is used and/or disclosed pursuant to a protected by federal privacy regulations and may be subject to re-disclosure 	nission, I will still be able to receive any needed to determine if I am eligible for this authorization, it may no longer be					
• 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 <u>either</u> for 90 days from the date of signature (if not other selecting one of these options:	erwise specified) <u>OR</u> as specified by					
☐ 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