AUTHORIZATION FOR RELEASE OF RECORDS

SEND OR FAX TO:
NF Clinical Program
c/o Anne Albers, PNP, MSN
Division of Pediatric Neurology
1260 Northwest Tower
Campus Box 8111
Washington University School of Medicine
St. Louis MO 63111
FAX: 314.454.2523
PHONE: 314.454.6120

I hereby authorize Washington University Physicians to (please circle on of the following) **transfer**, **release** or **obtain** information on:

Name of Patient: Date of Birth: Social Security Number:

OBTAIN FROM:

Physician/Institution: ______________________
Attention: ______________________
Address: ______________________
City, State, Zip Code: ______________________
Phone number: ______________________
Fax Number: ______________________

For the purpose of:

Please Check Specific Information Requested

	All Records		Laboratory Results		Progress Notes
	Discharge Summary		X-Ray Reports		Operative Report
	History & Physical		Emergency Room Report		Operative Notes
	Pathology		Nurse Notes		Endoscopy
	Medication Records		Nuclear Medicine Report		Other

Please Specify Other:

I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time to the extent that prior action has not been taken on this authorization. I also understand that my revocation of this authorization must be in writing. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Authorization is valid for 90 days from the date of signature unless revoked in writing. I have read and understand this consent and I have signed it voluntarily.

Signature: Relationship to Patient: Date:

Witness: Date:

Patient Address: Patient Phone: