Washington University in St. Louis

Psychological Service Center
West Campus, Campus Box 1172
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St. Louis, MO 63105
Phone: (314) 935-6555
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Procedure 5

Request for Access to Protected Health Information
By Individual Patients

Individual Patient Name: _____

Patient's Date of Birth: _____ Home/Cell Number: _____

The Psychological Service Center at Washington University is authorized to:

☐ Release Information To:
☐ Receive Information From: **Format:** ☐ Paper copy ☐ Fax ☐ Electronic copy

Name of Individual/Institution: _____
Mailing Address: _____
City, State, Zip Code: _____
Phone Number of Individual Receiving Records: _____ Fax Number: _____
Email Address*: _____
*Email is not a secure means of communication. We will encrypt email communications of your records unless you tell us you prefer us to use unencrypted email. If you prefer we not encrypt our communications to you, please initial here: _____

Date(s) of Treatment: ☐ Specific Dates: _____ through _____ ☐ All dates

Information to be Disclosed:
- ☐ Intake Report
- ☐ Termination Summary
- ☐ Neuropsychological report with summary of scores
- ☐ Neuropsychological report without summary of scores
- ☐ Verbal communication (no records released unless otherwise specified)
- ☐ Other: _____

Secondary release of information in the file from other sources not named in this authorization is
- ☐ Permitted
- ☐ Prohibited

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name Relationship to Individual