Washington University Physicians
Washington University School of Medicine in St. Louis

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Division of Cardiothoracic Surgery

PATIENT NAME: ______________________________ DOB: _______________
SS #: __________________________

PLEASE LIST YOUR DOCTORS BELOW:

	Doctor's Name	Specialty	Phone Number
1.		Primary Care/Family Doctor	
2.			
3.			
4.			
5.			
6.			

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Allergies: ______________________________

Authorization
TO DISCUSS MY PROTECTED HEALTH INFORMATION (PHI)

I authorize Washington University Thoracic Surgery, Physician and/or staff to discuss my Protected Heath Information (PHI) with the people listed below. This authorization allows us to give your test results and discuss your care with the people you designated (children, parents, siblings, friends, etc.).

1.) ______________________________

2.) ______________________________

3.) ______________________________

4.) ______________________________

5.) ______________________________

6.) ______________________________

______________________ ______________________
Patients Signature **Date**

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