Washington University in St. Louis

Authorization for the Use or Disclosure of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this protected health information may be used and/or disclosed pursuant to this authorization:

> **I hereby grant permission for the use of any of my medical records, including illustrations, photographs, imaging, office notes, operative notes, test results, or any other information related to my treatment, etc. for examination, testing, credentialing and/or certification purposes by The American Board of Plastic Surgery, Inc.**

2. I authorize the following persons (and or class of persons) to make the authorized use and/or disclosure of the specified protected health information:

Washington University Department of Surgery, Division of Plastic and Reconstructive Surgery.

3. I authorize the following persons (or class of persons) to receive my protected health information:

Any certifying body or board.

4. This authorization expires upon **my death**.
5. I understand that once my protected health information is used and/or disclosed pursuant to this authorization, it may no longer be protected by the privacy regulations and may be subject to re-disclosure by the recipient(s).
6. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy. I am aware that my revocation is not effective to the extent that I have authorized the use and/or disclosure of my protected health information and such use and/or disclosure has been relied upon by authorized recipients. I also understand that I may not revoke authorized use and/or disclosures obtained in connection with my receipt of insurance coverage.

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THE FOLLOWING PARAGRAPHS APPLY IF AUTHORIZATION IS REQUESTED BY WASHINGTON UNIVERSITY FOR ITS OWN USE:

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Washington University nor will it affect my eligibility for benefits. (OMIT #7 if the authorization applies to research-related activities, a health plan offering enrollment or eligibility benefits or specialized benefits pre-enrollment, or when Washington University is providing care solely for the purpose of creating PHI for disclosure to a third-party.)

Not applicable

8. My protected health information will be used or disclosed upon request for the following purposes (name and explain each purpose): _____

_____

_____

_____

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the Notice of Privacy.
10. I understand that Washington University will receive compensation for its use and/or disclosure of my protected health information. (OMIT #10 if not applicable).

Not applicable

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INCLUDE FOLLOWING PARAGRAPHS (IN ADDITION TO PARAGRAPHS 1-6 ABOVE) IF AUTHORIZATION IS REQUESTED BY WASHINGTON UNIVERSITY FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS:
7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Washington University, nor will it affect my eligibility for benefits. (OMIT #7 if the authorization applies to a health plan offering eligibility for specialized benefits).
8. My protected health information will be used or disclosed upon request for the following purposes (name and explain each purpose): _____

Not applicable

Not applicable

I certify that I have received a copy of the authorization.

_____	_____
Signature	Date
_____	
Name	
_____	_____
Name of Personal Representative	Relationship to Individual