Office Use Only MR#________________
❑ Mailed ❑ Fax ❑ In person/ID checked
❑ Workers Comp checked/Initials_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient: ______________________________ Date of Birth: ______________

Address: ______________________________ City: __________ State: ______ ZIP: ______

Telephone Number(s) (Cell #) ____________ (Home #) ______________ (Work #) ____________

Other names under which patient has been treated: ______________________________

Release Information From: (Specify Location(s))

☐ St. Luke's Hospital ____________________

☐ St Luke's Clinic ____________________

☐ Other *(Specify Name and Address below, including phone/fax if known)* ____________________

Release Information To: (Specify Location(s))

☐ St. Luke's Hospital ____________________

☐ St. Luke's Clinic ____________________

☐ Other *(Specify Name and Address below, including phone/fax if known)* ____________________

Purpose of Disclosure:

❑ Insurance ❑ Legal ❑ Personal ❑ Treatment / Continued Care ❑ Workers Compensation ❑ School
❑ Other ______________________________

This request is valid for services during the following:

The person(s) or entity(s) listed above may use or disclose information relating to the patient's care during the following:

Approximate service date(s) ______________________________

(Check one below)

❑ Records for service date listed above to current, until expiration of this form.

❑ Single disclosure for the date of service(s) specified above.

Information to be Disclosed:

❑ Billing Information ❑ Clinic Note ❑ Discharge Summary ❑ Emergency Room ❑ History Physical
❑ HIV/AIDS ❑ Imaging Film ❑ Imaging Report ❑ Immunization Record ❑ Lab/Pathology
❑ Medication List ❑ Operative/ Procedure Report ❑ Problem List ❑ Progress Note
❑ Substance Abuse ❑ Psych Evaluation/Assessment/Mental Health ❑ Therapy Notes ❑ Psychological Studies
❑ Breast Imaging (Mammo, Ultrasound, MRI) w/ report (CD or Film) ❑ Consultation Reports - Dr. Name: ____________
❑ Other: (Specify) ______________________________

I understand that I have the right to revoke this authorization at anytime except to the extent that action has been taken in reliance on this authorization. To revoke this authorization, I must submit a written revocation to **Health Information Management (Medical Records) at any St. Luke's Health Care Facility.**

I understand that my health care cannot be conditioned on this authorization unless;
(1) The purpose for evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or
(2) The patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by St. Luke's pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.

Additional Limitation of Redisclosure

- If information is disclosed from records protected by Federal confidentiality rules (42 CFR part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted, in writing, by the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

This authorization will expire one (1) year from date signed.

______________________________ ____________ ____________
Signature **Date** **Time**

____
Relationship to the Patient ***Note: Authority of individuals who are acting on behalf of the patient will be verified.***