



Office Use Only MR# _____
 Mailed Fax In person Workers Comp
 ID checked /Initials _____

AUTHORIZATION TO ACCESS, USE, AND 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: _____

<p>Release Information From: The following entity/individual is authorized to disclose my PHI:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____ Fax: _____</p> <p><i>If St. Luke's:</i> <input type="checkbox"/> Hospital Name: _____ <input type="checkbox"/> Clinic Name: _____</p>	<p>Release Information To: The following entity/individual is authorized to access, use, and receive my PHI:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____ Fax: _____</p> <p><i>If St. Luke's:</i> <input type="checkbox"/> Hospital Name: _____ <input type="checkbox"/> Clinic Name: _____</p>
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Purpose of Use and Disclosure:

<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	<input type="checkbox"/> Personal	<input type="checkbox"/> Treatment/Continued Care	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> School
<input type="checkbox"/> Occupational Services	<input type="checkbox"/> Employee Wellness	<input type="checkbox"/> Other _____			

This request is valid for services for the following dates: Select one of the following options

<input type="checkbox"/> Approximate service date(s) _____.
<input type="checkbox"/> All visits between the dates _____ and _____.
<input type="checkbox"/> All visits between the date _____ and the expiration date of this form.

Information to be Used or Disclosed:

<input type="checkbox"/> Billing Information	<input type="checkbox"/> Imaging Film	<input type="checkbox"/> Medication List
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Imaging Report	<input type="checkbox"/> Problem List
<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Immunizations and/or Titers	<input type="checkbox"/> Therapy Notes
<input type="checkbox"/> History/Physical	<input type="checkbox"/> Lab/Pathology	<input type="checkbox"/> Drug and/or Alcohol Results
<input type="checkbox"/> Clinic/Progress Notes	<input type="checkbox"/> Operative/ Procedure Report	<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Medical Clearance	<input type="checkbox"/> Employment/DOT Physical	<input type="checkbox"/> Breast Imaging (Mammo, Ultrasound, MRI) w/report (CD or Film)
<input type="checkbox"/> Mental Health Evaluation/Studies	<input type="checkbox"/> Biometric Screening	<input type="checkbox"/> Substance Use Disorder
<input type="checkbox"/> Health Assessment		
<input type="checkbox"/> Other: (Specify) _____		

Choose one format for receiving the information: Paper Fax Electronic copy Other _____

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and genetic testing. **Please note that psychotherapy notes require a separate authorization.**

I understand that I have the right to revoke this authorization at any time 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 the purpose is solely to obtain and disclose information for a third party, such as an employer.

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.

Signature _____ **Date** _____ **Time**

Relationship to the Patient (if applicable)

THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM DATE SIGNED.