Office Use Only MR#________________
❑ Mailed ❑ Fax ❑ In person ❑ Workers Comp
❑ ID checked 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: ___________________________________________________________________

| **Release Information From:** The following entity/individual is authorized to disclose my PHI: | **Release Information To:** The following entity/individual is authorized to access, use, and receive my PHI: |
|---|---|
| Name: ____________________________________ | Name: ____________________________________ |
| Address: __________________________________ | Address: __________________________________ |
| __________________________________________ | __________________________________________ |
| Phone: _______________ Fax: __________________ | Phone: _______________ Fax: __________________ |
| ***If St. Luke's:*** ☐ Hospital Name:_____________________ | ***If St. Luke's:*** ☐ Hospital Name:_____________________ |
| ☐ Clinic Name:_______________________ | ☐ Clinic Name:_______________________ |

**Purpose of Use and Disclosure:**

❑ Insurance ❑ Legal ❑ Personal ❑ Treatment/Continued Care ❑ Workers Compensation ❑ School
❑ Occupational Services ❑ Employee Wellness ❑ Other _____________________________________________

**This request is valid for services for the following dates: Select <u>one</u> of the following options**

❑ Approximate service date(s) ___________________________________________.
❑ All visits between the dates ___________________and _____________________.
❑ All visits between the date ___________________ and the expiration date of this form.

**Information to be Used or Disclosed:**

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

***Choose <u>one</u> 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. **<u>To revoke this authorization</u>, 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.**