St. Luke's Hospital

1HIPAA

Authorization for Release of Information

Patient Name: ______________________________ Date of Birth: ______________________________

Street Address: ______________________________ Last 4 numbers of SSN: ____________________

City, State, Zip: ______________________________ Telephone: (   ) ______________________________

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Release Information From:	**Release Information To:**
______________________________ (List applicable Facility(s) and/or Practice(s))	______________________________ (Name of facility, person, company) (Relationship)
______________________________	______________________________ (Street Address or PO Box, City, State, Zip Code)
______________________________ (Phone number) (Fax number)	______________________________ (Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance ☐ Legal purpose including discussions & proceedings ☐Other______________________________

Fill in dates of treatment for records to be released:

Treatment dates: From ______________________________**To** ______________________________

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.

Hospital (check all that may apply):

- ☐ Hospital Summary
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation reports
- ☐ Operative Reports
- ☐ Laboratory reports
- ☐ Radiology/X-Ray Reports
- ☐ Pathology reports
- ☐ Emergency Record
- ☐ Cardiac Reports/EKG
- ☐ Other______________
- ______________
- ______________
- ______________
- ______________
- ☐ Entire record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):

- ☐ Hospital Summary
- ☐ Assessments
- ☐ Discharge Summary
- ☐ Physician Orders
- ☐ Progress notes
- ☐ Medications
- ☐ Lab reports
- ☐ Other ______________________________
- ☐ Entire Record (Not including psychotherapy notes)

MED REC #	**VISIT ID #**

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **St. Luke's Hospital will not share or use my health information without my permission other than by ways listed in St. Luke's Hospital's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at www.saintlukeshospital.com.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form.**

This permission expires one year after the date of my signature unless another date or event is written here: ______________________

Signature: ______________________________ **Print Name:** ______________________________ **Date:**______________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** ______________________________

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health condition without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of whom consented for treatment.

Signature of Minor:______________________________ **Print Name:** ______________________________ **Date:** ______________

Authorization given to patient / Date of release:__________________via ☐Mail ☐Fax ☐ Hard Copy ☐**ID Verified** ☐**DL/Other ID**____________________

SLH Employee Signature ____ **Date** ______________________________

MEDREC045