St Luke's

Office Use Only

MR#_____
❑ Mailed ❑ Fax ❑ In person/ID checked
❑ Workers Comp checked/Initials_____

FAX Form to 208-381-4663

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:

☐ St. Luke's

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

_____

_____

Release Information To:

☐ St. Luke's

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

_____

_____

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

For approximate service date(s)_____

This request is valid for services during the following (check one):

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

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

Purpose of Disclosure:

❑ Insurance ❑ Legal ❑ Personal ❑ Treatment / Continued Care ❑ Workers Compensation ❑ Other _____

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 ❑ 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**

_____

Authority or Relationship to the Patient