AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT HEALTH INFORMATION

☐ **St. Luke's Rehabilitation Institute Releasing Information** ☐ **St. Luke's requesting Information**

1. PATIENT IDENTIFICATION	
Patient's Full Name:	**Date of Birth:**
Name Used at Time of Treatment:	**Phone Number:**

2. PURPOSE OF RELEASE OR REQUEST

☐ Continuing Care ☐ Personal Use ☐ Worker's Compensation
☐ Legal ☐ Coordination with School ☐ Other (specify): _____

3. RECORDS TO BE RELEASED (Select all that apply)		
☐ **Inpatient Medical Records**	☐ **Mental Health Records**	☐ **Emergency department records**
☐ **Outpatient Medical Records**	☐ **Sexually Transmitted Diseases (HIV)**	☐ **Imaging Reports**
☐ **Therapy Services Records**	☐ **Substance Abuse Records**	☐ **Lab/Pathology Reports**
☐ **Discharge Summaries**	☐ **Operative reports**	☐ **Other (specify):**

4. RELEASE REQUIRING SPECIFIC CONSENT

Minors: Emancipated minors must be treated like an adult in releasing his/her health information otherwise a minor patient must authorize the release of the following: 1) conditions related to reproductive care; 2) sexually transmitted (i.e., HIV) diseases (14 and older); 3) mental health conditions (age 13 and older); and 3) substance (alcohol/drugs) use disorder records.
Adults: Adults must specifically authorize release of the following information: 1) mental health records; 2) sexually transmitted diseases (i.e., HIV); and 3) substance (alcohol/drugs) use disorder records.

5. RIGHTS OF THE PATIENT

I acknowledge the following:

- This authorization is voluntary and I may refuse to sign this form without being denied treatment, payment and/or enrollment for benefits.
- This authorization is valid for not more than one (1) year from the date of the signature below or until the following event _____and/or date _____/_____/_____ if less than one year.
- I understand that I may also revoke this authorization at any time by notifying in writing the Health Information Management Department, but disclosures of health information may have already occurred relying on this authorization.
- Any disclosures made pursuant to this release is potentially subject to redisclosures by the recipient, whom may not be subject to the same privacy/confidentiality requirements as St. Luke's or no privacy/confidentiality requirements.

6. RECIPIENT(S) OF HEALTH INFORMATION

I authorize _____ [Facility/Provider/Organization] to release information to:

Name of Legal Entity/Individual/Class of Persons (Recipients): _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Telephone Number: _____ **Fax Number:** _____

7. SIGNATURE OF PATIENT/LEGAL SURROGATE	
Signature:	**Date:**
Relationship to Patient: **Description of basis to act for patient (i.e., legal guardian, power of attorney):**	**ID Check:** ☐ **Yes** ☐ **No**

8. MEDIUM FOR DISCLOSURE OF INFORMATION

☐ Paper record (if no boxes checked paper records will be provided)
☐ Electronic; cost based fees apply for encrypted USB drive
☐ Verbal only

For office use only:
Medical Record #_____
Account #_____