St. Luke's Medical Center
Patient Request to Inspect and/or Obtain a Copy of Protected Health Information

I desire access to and/or copies of medical information created and maintained by St. Luke's Medical Center. I authorize St. Luke's Medical Center to copy and/or disclose to me my health information.

Patient Name: ______________________________

Social Security Number: ____________________ Date of Birth: ____________

PURPOSE FOR USE / DISCLOSURE______________________________

Approximate date(s) of service to be used/disclosed ______________________________

INFORMATION TO BE USED / DISCLOSED

- ❑ Consultation Report(s)
- ❑ Emergency Room Record
- ❑ Operative/Procedure Report
- ❑ Discharge Summary
- ❑ History and Physical
- ❑ Pathology Report
- ❑ EKG Reports(s)
- ❑ Lab Reports
- ❑ Radiology Reports/films
- ❑ Other______________________________

I understand that this information may include information relating to: Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV): treatment for drug or alcohol abuse; or mental or behavioral health or psychiatric care, excluding psychotherapy notes.

I desire access to my protected health information as follows:

1. The information identified above should be sent to me at the following address:

   ______________________ ________ ____ ____
   Address City State Zip

2. I would like to pick up the information noted above on the following dates and time:

   ____________ ____________
   Date Time

3. I want to review my protected health information, but I do not need a copy. I would like to review the information noted above on the following date and time:

   ____________ ____________
   Date Time

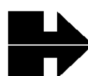
I understand that St. Luke's Medical Center may charge a fee for the cost of copying, mailing, or other supplies associated with this request (not to exceed the community standard), and such fees must be paid in advance.

I understand that St. Luke's Medical Center may deny my request to inspect and obtain a copy of my protected health information in certain limited circumstances. I understand that if I am denied the opportunity to inspect and obtain a copy of my protected health information, I may request that the denial be reviewed in certain situations.

______________________________ ______________________________
Signature of Patient or Patient's Representative Printed Name of Patient or Patient's Representative

______________________________ ____________ ____________________
Relationship to Patient Date Daytime Telephone Number

Account Number:	MR Number:
Patient Name:	
Admit Date:	



St. Luke's
Medical Center
1800 E. Van Buren St. – Phoenix – AZ 85006
(602) 251-8100

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC

Allergies:

Attending Physician Name: