Authorization for Use and Disclosure of Protected Health Information

Print Patient Last Name _____ First _____ Middle _____
Address _____ City _____ State _____ Zip _____
Social Security Number _____ Date of Birth _____ Phone _____

I authorize St. Luke's Medical Center to disclose protected health information to:

Name _____ Phone/Fax Number _____
Address _____ City _____ State _____ Zip _____

☐ Call this phone number when records are available for pick up at hospital _____

PURPOSE FOR USE/DISCLOSURE _____
Approximate date(s) of service to be used/disclosed _____

INFORMATION TO BE USED / DISCLOSED

☐ Emergency Room Record
☐ Discharge summary
☐ History and Physical
☐ Operative/procedure report
☐ Consultation report(s)
☐ Other _____
☐ Pathology report
☐ Lab reports
☐ Radiology reports/films
☐ EKG report(s)

Specific Authorization to Disclose Sensitive Records

I UNDERSTAND THAT THIS AUTHORIZATION IS TO INCLUDE USE / DISCLOSURE OF: *(please check and initial)*

☐ Alcohol and/or drug abuse records *Initials* _____
☐ Sexually transmitted disease information *Initials* _____
☐ Psychiatric records *Initials* _____
☐ HIV/AIDS information *Initials* _____

*This information is disclosed from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization is NOT sufficient for this purpose.

- I understand that I may revoke this authorization, in writing, at any time except to the extent that St. Luke's Medical Center has already relied on this authorization.
- I understand that I may revoke this authorization by sending or faxing a written notice to the Privacy Officer, at St. Luke's Medical Center, 1800 East Van Buren Street, Phoenix, AZ 85006 or fax 602-251-8207, stating my intent to revoke this authorization.
- Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is one year after signing and dating this form, unless otherwise documented here:_____
- I understand that St. Luke's Medical Center may not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization form.
- I understand that information being disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the Federal privacy law, if the recipient is not a "covered entity".

☐ If box is checked, the hospital will receive direct or indirect financial compensation in connection with the use or disclosure of your information for marketing purposes.

_____ _____
Signature (Patient or Patient's Legal Representative) Date

_____ _____
Printed Name of Legal Representative Relationship to Patient

PLEASE NOTE: THIS FORM MUST BE COMPETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.

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: