St. Luke's Behavioral Health Center
A STEWARD FAMILY HOSPITAL

1800 E. Van Buren Street
Phoenix, AZ 85006
602-251-8535

St. Luke's Behavioral Health Center
Patient Request / Authorization to Use and/or Disclose Protected Health Information

☐ Request Completed by _____ (staff initial) Medical Record # _____

I hereby authorize **St. Luke's Behavioral Health Center** to use and/or disclose the Protected Health Information specified below from my medical records:

1) PATIENT NAME: (Please Print) _____ Date of Birth: _____

Address: _____
Street City State Zip

Contact Telephone Number(s): _____

Email: (if applicable) _____

2) INFORMATION TO BE DISCLOSED TO:

_____
Person or Facility Name (Please print)

_____
Address (Please print) City State Zip

_____
Email: (if applicable)

Fax # _____

Phone # _____

3) Preferred Delivery Method -

- ☐ **Email**
- ☐ **Postal Mail to address in # 2 above**
- ☐ **In Person Pick-Up**

4) Treatment Dates From: _____ **To:** _____

5) SPECIFIC RECORDS/REPORTS(S) TO BE RELEASED:

☐ Admission History and Physical	☐ Laboratory Results	☐ Rehab Services (PT, OT, Speech)
☐ Discharge Summary	☐ Imaging Reports (Specify CT, X-Ray, MRI)	☐ Other (be specific)
☐ Consultation	☐ Pathology Reports	_____
☐ Emergency	☐ Operative Notes	_____
☐ EKG Reports		

6) RESTRICTED RELEASE: We will **not** disclose the following documentation **unless** you check the box and provide an additional signature:

Release	Signature	Release	Signature
☐ Mental/Behavioral Health Provider Documentation*		☐ Genetic Testing/Test Results*	
☐ HIV/AIDS Screening Test Results		☐ Alcohol*** Treatment*** and/or ☐ Substance Abuse	
☐ Confidential Communications with a Social Worker		☐ Child/Elder Abuse and Neglect	
☐ Rape/Sexual Assault Victim's Counseling		☐ Domestic Violence Victim's Counseling	
☐ Sexually Transmitted Disease			

* This authorization is not valid for use or disclosure of psychotherapy notes

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

***Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment." (42 CFR Part 2) Not required for records created or maintained by a general medical facility.

IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL APPLICABLE ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2