

# 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

### 7) EXCLUSION REQUEST:

I request that the following admission(s) / visit(s) be specifically excluded from this request \_\_\_\_\_ (specify dates of service)

### 8) PURPOSE OF THE DISCLOSURE:

Medical Care  Legal  Insurance  Personal  Other \_\_\_\_\_

\*fees may apply

### 9) TERM: This Authorization will remain in effect for one year or:

- Until **St. Luke's Behavioral Health Center** fulfills this request.
- From the date of this Authorization until the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_
- Until the following event occurs: \_\_\_\_\_
- Other: \_\_\_\_\_

**10) REVOCATION:** I understand that I may revoke this Authorization at any time by requesting it of **St. Luke's Behavioral Health Center** in writing at the address listed below. The revocation will be effective immediately upon **St. Luke's Behavioral Health Center** receipt of my written notice. I understand that the revocation will not have any effect on any action taken by **St. Luke's Behavioral Health Center** reliance on this Authorization before it received my written notice of revocation.

#### Attention Health Information Management

#### St. Luke's Behavioral Health Center

1800 East Van Buren Street,  
Phoenix, AZ 85006

**11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIGIBILITY:** I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment, payment, health plan enrollment or eligibility for benefits at **St. Luke's Behavioral Health Center**.

**12) POTENTIAL FOR REDISCLOSURE:** I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by **St. Luke's Behavioral Health Center**.

**13) ACCESS:** I understand that in certain circumstances **St. Luke's Behavioral Health Center** has the right to deny me access to all or portions of my Protected Health Information **St. Luke's Behavioral Health Center** will notify me in writing of any such denials.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize **St. Luke's Behavioral Health Center** to use and/or disclose my health information in the manner described above.

14) \_\_\_\_\_  
Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Patient \_\_\_\_\_ Witness \_\_\_\_\_

For Office Use: <input type="checkbox"/> I.D Verification _____
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Authorized patient representative signature. If the patient is a minor or is otherwise unable to sign this Authorization:

15) \_\_\_\_\_  
Signature of Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Printed name of Patient Representative \_\_\_\_\_ 15) \_\_\_\_\_  
Relationship to patient or authority to act for patient \_\_\_\_\_

Questions about the release should be directed to the hospital HIM Director.

For Office Use:

- Copy of this authorization provided to the patient
- Copy of this authorization provided to the personal representative

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



Authorization for Use and Disclosure of Protected Health Information (HIM 44)  
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