

# St. Luke's Patient Portal Enrollment Form

Patient Name: \_\_\_\_\_

*\*Please Print*

Last 4 Digits of Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Each patient must have a unique email address. Email Account to be used to access **mystlukes** Patient Portal:

**Choose Appropriate Option Below:**

St. Luke's Hospital Patient including Outpatient Testing.

St. Luke's Medical Group Patient  
Name of Medical Group Practice(s)/Provider(s) \_\_\_\_\_

I understand that **mystlukes** is intended as a secure online source of confidential medical information. If I share **mystlukes** ID and password with another person, that person may be able to view my health information, and information about someone who has authorized me as a **mystlukes** proxy.

I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe that it may have been compromised in any way.

I understand that the use of **mystlukes** is voluntary and that I am not required to use **mystlukes** or to authorize **mystlukes** proxy. I understand that I have the right to deactivate access to **mystlukes** patient portal at anytime for any reason.

I understand that access to **mystlukes** is provided by St. Luke's as a convenience to its patients and that St. Luke's has the right to deactivate access to **mystlukes** at any time for any reason.

I understand that **mystlukes** contains selected, limited medical information from a patient's medical record and that **mystlukes** does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the hospital or my physician's office.

I understand that if I authorize another person (proxy) to access my **mystlukes** portal account, the information to be used or disclosed pursuant to this authorization may include information relating to (1) AIDS or HIV infection; (2) treatment of drug or alcohol use; or (3) mental or behavior health or psychiatric care; or (4) sexually transmitted diseases.

I have read the above information and authorize disclosure of the identified information to the person/organization and for the purpose described herein. I understand that by signing this document, I release and discharge the disclosing St. Luke's Hospital and/or St. Luke's Medical Group from any liability and will hold it harmless for any release made pursuant to the authorization.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Mail Completed Form(s) To:**

St. Luke's Hospital  
Health Information Services – Correspondence

101 St. Luke's Center Drive  
Chesterfield, MO 63017

**Fax Completed Form(s) To:**

Fax #: (314)-205-6106

**For Questions About this  
Form Call:**

(314)-542-4729

8:30am-4:30pm Monday - Friday