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 *my*stlukes Patient Portal:

_____

Choose Appropriate Option Below:

☐ St. Luke's Hospital Patient
Date of Hospital Admission: _____

☐ St. Luke's Medical Group Patient
Name of Medical Group Practice(s)/Provider(s) _____

I understand that *my*stlukes is intended as a secure online source of confidential medical information. If I share *my*stlukes 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 *my*stlukes 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 *my*stlukes is voluntary and that I am not required to use *my*stlukes or to authorize *my*stlukes proxy. I understand that I have the right to deactivate access to *my*stlukes patient portal at anytime for any reason.

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

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

I understand that if I authorize another person (proxy) to access my *my*stlukes 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

111 S. Woods Mill Road
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