ROI1001

Return completed form to:
St. Luke's Hospital Health Information Services
FAX: (314) 205-6106

Patient Name: _____ Treatment Date: _____
Please print

Date of Birth: _____ Phone: _____

Purpose of Request: _____

I hereby authorize: _____

To Release Record To:	To Obtain Record From:
Street Address:	Organization:
City, State, Zip:	Address:

I specifically authorize the use and disclosure of the following:

☐ **Clinical Abstract**
includes all documents listed →

OR

☐ Discharge Summary
☐ History & Physical
☐ Consultation Reports
☐ Operative Reports
☐ ER Physician Note
☐ Laboratory Reports
☐ Radiology Reports
☐ Cardiology Reports

☐ Other (please specify): _____

☐ Complete Record (entire medical record including nursing notes and orders)

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 behavioral health or psychiatric care; (4) sexually transmitted disease; or (5) genetic testing.

Except: _____

I may revoke this authorization in writing at any time. I understand that such revocation will not have any effect on the information already used or disclosed before receipt of my written notice of revocation. Unless earlier revoked, this authorization will expire one year from the date it was signed. I understand I may choose to restrict or extend the expiration date. I may request to inspect or copy the information to be disclosed. I may refuse to sign this authorization. I understand that I am not required to sign the authorization to receive treatment. Once release of this information is made to the above named person/organization, my information may be subject to re-disclosure by the recipient.

I may be charged fees for the copying of such information if I am requesting information for myself or for a third party. Such fees will comply with state and federal laws.

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 entity from any liability and will hold it harmless for any release made pursuant to the authorization.

_____ _____ _____
Signature of Patient/Legal Guardian/Personal Representative | Date | Time

_____ _____ _____
If someone signs on behalf of the patient, state your relationship to the patient | Date | Time

Authorization Expires: _____
(up to one year if not otherwise specified)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

St. Luke's Hospital
232 So. Woods Mill Rd Chesterfield, MO 63017

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