

Release of Protected Health Information

800 East Park Boulevard Boise, Idaho 83712

Please use this form to give St. Luke's Health Plan the right to use and disclose your personal, private health information (PHI) to the extent permitted by law.

### Member (the person whose information is being released):

Full Name:				DOB:	
i un runno.	Last	First	M.I.		
Address:					
,	Street Address				Apartment/Unit #
	City		State	Zip Code	•
Phone:			Member ID:		

# The person(s) or entity to whom PHI can be disclosed:

Full Name:				DOB:		
	Last	First	M.I.			
Address:					<b>A</b>	
	Street Address				Apartment/Unit #	
	City		State		Zip Code	
Phone:			Member ID:			

# Description of information to be used or disclosed:

### Type of information:

All psychotherapy notes about me maintained by St. Luke's Health Plan

Any psychotherapy notes pertaining to the following topic(s):

All psychotherapy notes about me for dates between	and	ud

All psychotherapy notes about me pertaining to \_\_\_\_\_\_between \_\_\_\_\_(date) and \_\_\_\_\_(date)

Note: Items not checked above will not be used or disclosed, unless permitted by law

# The purpose of the requested disclosure:

At my request*	Personal use
Continued medical care	Insurance claim
Insurance application	Social Security/Disability determination
Military	School
Legal purposes	Other (please specify)

\*This option is the sufficient description when an individual initiates the authorization and does not, or elects not to, provide a statement of purpose.

### **Expiration date:**

This authorization shall remain valid (unless revoked in writing) until:

One year from the date I sign it

The following date: \_\_\_\_

Until the following event occurs: \_\_\_\_\_

#### Signature

By signing below, I acknowledge understanding that:

- 1. I may revoke this authorization at any time in writing, and upon request, St. Luke's Health Plan will furnish me with a form to make my written revocation, but I am not required to use that form to make my written request for revocation.
- 2. My revocation will not apply to the information that has already been released as permitted by this authorization.
- 3. St. Luke's Health Plan may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- 4. The person(s) to whom this information is disclosed may re-disclose the information, and it will no longer be protected by federal health information privacy law.
- 5. I have a right to request and receive a copy of this authorization.

# I have read and understand this Authorization for Release Protected Health Information (PHI), I have signed the form voluntarily and have received a copy of it:

Name:	 	 	
Signature:	 	 	

Relationship	to member:	

# Verification (Internal Use Only)

Identity of individual verified

Identity of Representative and their authority to act verified

Received and confirmed for St. Luke's Health Plan by:

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

Name of employee: \_\_\_\_\_

Email the form to **customerservice@slhealthplan.org.** For questions, call **833-840-3600.**