St Luke's™ + Health Plan

Release of Protected Health Information

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: _____
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: _____
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 _____

☐ 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*
- ☐ Continued medical care
- ☐ Insurance application
- ☐ Military
- ☐ Legal purposes
- ☐ Personal use
- ☐ Insurance claim
- ☐ Social Security/Disability determination
- ☐ School
- ☐ 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: _____