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 PHI is being used or disclosed):

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: ______________

The purpose of the requested disclosure:

At my request*

Continued medical care

Insurance application

Military

Legal purpose

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

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Information to be used or disclosed:

Please check the box describing the PHI you are requesting to be used or disclosed. If none of the options below apply, please check "Other" and provide a brief description.

All health information	Laboratory reports
Pathology reports	Medication records
Test reports	Discharge summary
Imaging reports (X-ray)	Other (specify): ____________________
History and physical	Itemized billing statement

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

Sensitive information to be used or disclosed:

I understand that my records may contain information related to history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment, and genetic information. If my records contain any such information, I authorize the use or disclosure of that information as follows (select all that apply):

HIV or AIDs	Mental illness or psychiatric treatment
Sexually transmitted infections or testing	Genetic information
Drug and/or alcohol abuse	Other (specify): ____________________

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

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: ____________________

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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 of 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: ______________________________ (Employee name)

Signature: ______________________________ Date: ____________________