

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.

- | | |
|--|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Medication records |
| <input type="checkbox"/> Test reports | <input type="checkbox"/> Discharge summary |
| <input type="checkbox"/> Imaging reports (X-ray) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> History and physical | <input type="checkbox"/> 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):

- | | |
|---|--|
| <input type="checkbox"/> HIV or AIDs | <input type="checkbox"/> Mental illness or psychiatric treatment |
| <input type="checkbox"/> Sexually transmitted infections or testing | <input type="checkbox"/> Genetic information |
| <input type="checkbox"/> Drug and/or alcohol abuse | <input type="checkbox"/> 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: _____

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: _____

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