



77 South Commerce Way, Suite 100
 Bethlehem, PA 18017
 484-526-4719 Fax: 1-833-932-1185
 Email: releaseofinformation@sluhn.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

SECTION 1: Patient Information

****For timely processing, please PRINT clearly.**

PATIENT NAME (Please include recent name changes or aliases)				DATE OF BIRTH	
ADDRESS	CITY	STATE	ZIP	TELEPHONE #	

SECTION 2: Location(s) of Care

HOSPITAL	SLUHN HOSPITAL CAMPUSES: <i>If requesting hospital records please check off one of the below boxes and specify location.</i> <input type="checkbox"/> Hospital Location(s): _____ <input type="checkbox"/> St Luke's University Health Network: Entire Network Search
PRACTICE PROVIDER	SLPG PHYSICIAN OFFICES: <input type="checkbox"/> ALL LOCATIONS FOR THIS SPECIALTY Name of Practices or Providers: _____ Address: _____ City/State/Zip: _____ Phone: _____
NON-SLUHN	Locations: _____ Address: _____ City/State/Zip: _____ Phone: _____

SECTION 3: Release Records To (Where do you want us to send your records)

I consent to and authorize the release of information from my medical record from the above location(s) to:	
NAME OF DOCTOR/HOSPITAL/PERSON/OTHER/SELF	PHONE #
ADDRESS	FAX #

SECTION 4: Method of Sending Records (How do you want us to send your medical records?)

<input type="checkbox"/> Secure Email: _____
<input type="checkbox"/> Fax: _____
<input type="checkbox"/> Mailing Address: _____
<input type="checkbox"/> REQUESTED ON ELECTRONIC MEDIA (ALL RECORDS PROVIDED ON CD AND MAILED)

SECTION 5: Specific Date of Service/Information to be Released: *Please complete date range and document selection below*

The information to be released will cover the time from _____ to _____ (cannot be a future date)	
<input type="checkbox"/> Record Summary (key documents from chart) <input type="checkbox"/> Discharge Instructions (AVS) <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> Office Notes/Visit Notes <input type="checkbox"/> Immunizations <input type="checkbox"/> History & Physical (H&P) <input type="checkbox"/> Therapy Notes (PT, OT, Speech) <input type="checkbox"/> Operative Reports <input type="checkbox"/> Other: _____ <input type="checkbox"/> Exception: I do not give permission to release: _____	<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Lab Reports <input type="checkbox"/> X-Ray/Imaging Reports <input type="checkbox"/> Radiology/ Imaging on CD <input type="checkbox"/> EKG, EEG, Stress Tests <input type="checkbox"/> Vascular Studies



SECTION 6: Special Authorizations for HIV, Mental Health and Drug / Alcohol Records:

I understand & authorize the release of this information unless noted on first page as exception.
 I also understand that my record may contain:

- AIDS/HIV-Related Information if AIDS/HIV-related tests were ordered by my physician; Confidentiality of HIV-Related Information Act, PA Law Act 148
- Mental Health Information, if mental health treatment was given by my physician, PA Mental Health Procedure Act
- Drug or Alcohol Information, if drug or alcohol tests were ordered or treatment provided by my physician. Drug & Alcohol Abuse Control Act 42 CFR Part 2; 71 P.S. 1690.108(c)

SECTION 7: Authorization Signatures

I understand that the provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
 I acknowledge that the information disclosed pursuant to this release may be subject to redisclosure by the recipient.
 I understand that I may revoke this release at any time, in writing, except to the extent that St. Luke's has already relied on it in making a disclosure. My written revocation will become effective when St. Luke's receives it. If I wish to revoke this release, I will send a written request to: St. Luke's University Health Network, Medical Records Department, 77 Commerce Way, Bethlehem, PA 18017.
 I understand that this release will remain effective for a period of one year from the date of my request unless otherwise specified.

_____ Date _____
 Patient / Authorized Person Signature

_____ Time _____
 Patient / Authorized Person Printed Name

Relationship: _____

Unable to sign because: _____

Patient Identification: Photo I.D.: _____ Other: _____ POA: _____

Is patient a minor? Yes No

- If Yes, are there any legal restrictions of your authority to act on behalf of the minor? Yes No
- If Yes, Legal documentation provided? Yes No

INTERNAL USE ONLY:

PATIENT: Received Refused a copy of this form Verbal Request: _____

Information released to: _____ Date: _____ Time: _____

Information released by: _____ Date: _____ Time: _____

