St Luke's HOSPITAL & Health Network

☐ Allentown and Bethlehem Campuses
1510 Valley Center Parkway, Suite 240
Bethlehem, PA 18017
610-954-4719 Fax 610-954-4724

☐ Miners Memorial Campus
360 West Ruddle Street
Coaldale, PA 18218
570-645-8170 Fax 570-645-8373

☐ Quakertown Campus
1021 Park Avenue
Quakertown, PA 18951
215-538-4694 Fax 215-529-5299

MEDICAL INFORMATION RELEASE

Encounter number _____ **Medical Record Number** _____

Date/Time Request Received _____

PATIENT NAME	DATE OF BIRTH
PATIENT ADDRESS	PHONE NUMBER

I authorize: _____ to release my Medical Records to: _____

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

NAME OF DOCTOR/HOSPITAL/INSURANCE COMPANY/OTHER AGENCY

ATTENTION

ADDRESS AND/OR FAX # / PHONE #

FOR THE PURPOSE OF

ATTENTION PATIENT

I understand & authorize the release of this information unless noted below 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

Date(s) of Service _____

☐ Consultation Report
☐ Discharge Summary
☐ EKG, EEG, Stress, ECHO
☐ Emergency Dept Records
☐ Face Sheet/Demographics Sheet
☐ Films/CD
☐ History & Physical
☐ Laboratory Results
☐ Operative Report
☐ X-Ray Report/CVL Report
☐ Other _____

☐ **EXCEPTION: I do not give permission to release (please specify):** _____

I understand that the provider may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I acknowledge that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it is given unless revoked by me.

I understand that my authorization will remain effective for a period of 90 days from date of my request.

_____
Patient's Signature/Date

_____
Signature of Authorized Person/Date

Relationship: _____

Patient Identification
☐ Photo I.D.
☐ Other _____
☐ POA Provided

☐ Unable to sign because: _____

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

Information released to: _____ Date/Time: _____

Information released by: _____ Date/Time: _____

15034

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MEDICAL INFORMATION RELEASE

White - Chart Copy
Yellow - Patient Copy