St Luke's Penn Foundation
MENTAL HEALTH SERVICES

☐ St. Luke's Psychiatric Associates – Bethlehem
☐ St. Luke's Psychiatric Associates – Lehighton
☐ St. Luke's Walk-In Center – Lehighton
☐ St. Luke's Penn Foundation
☐ St. Luke's Partial Hospital Program
☐ St. Luke's Psychiatric Associates – Phillipsburg
☐ St. Luke's Psychiatric Associates – Chew St
☐ St Luke's Psychiatric Associates – Hamilton St
☐ St. Luke's Sacred Heart Campus
☐ St. Luke's – Lehighton Campus
☐ St. Luke's Quakertown Campus
☐ St. Luke's Easton Campus
☐ Other: _____

MENTAL HEALTH MEDICAL INFORMATION RELEASE

PHONE: 484-822-5700
FAX: 484-822-5795

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:

NAME OF DOCTOR/HOSPITAL/INSURANCE COMPANY/OTHER AGENCY

ATTENTION

ADDRESS AND/OR FAX #/ PHONE #

FOR THE PURPOSE OF

- 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

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; 71 P.S. 1690.108(c)

Date(s) of Service: _____

☐ **REQUESTED ON ELECTRONIC MEDIA**

☐ Initial Biopsychosocial Assessment
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Psychotherapy Notes
☐ Discharge/Transfer Summary
☐ Medication Management Information
☐ Current Medication List
☐ Treatment Plan/Summary
☐ Crisis/Safety Plan
☐ Appointment Schedule (Past and Future)
☐ Other: _____

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 release may be subject to redisclosure by the recipient.
I also understand that this release may be reviewed 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 release will remain in force in order to effectuate the purposes for which it is given unless revoked by me.
I understand that this release will expire on _____ (no more than one year from date of your signature)

Patient's Signature: _____ Date: _____
Signature of Authorized Person: _____ Date: _____
Relationship: _____
☐ Unable to sign because: _____

Witness: _____ Date: _____ Time: _____
Witness: _____ Date: _____ Time: _____
Staff reviewing content with Patient/Authorized Person Signature: _____
Print Name: _____ Date: _____ Time: _____

PATIENT ☐ Received ☐ Refused a copy of this form ☐ Verbal Request _____
Information released to: _____
Information released by: _____