☐ SLUHN HOSPITAL CAMPUSES
77 South Commerce Way, Suite 100
Bethlehem, PA 18017
484-526-4719 Fax: 1-833-932-1185
Email: releaseofinformation@sluhn.org
☐ SLPG PHYSICIAN OFFICES

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: ______________________

☐ **For Continuation of Care**

☐ **For Personal Use (Insurance/Legal)**

Address: ______________________

- 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

Appt. Date: ______________________
Phone/Fax: ______________________
Email Address: ______________________

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**

☐ D/C Summary ☐ Consult ☐ CD/Film
☐ X-Ray Report ☐ H & P ☐ **SLPG Office Notes – *See other side to list physician***
☐ Operative Report ☐ ED ☐ Other: ______________________
☐ EKG, EEG ☐ Vascular
☐ Stress, ECHO ☐ Labs

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

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 authorization may be subject to redisclosure by the recipient.

I understand that I may revoke this authorization 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 authorization, 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 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: ______________________

Unable to sign because: ______________________

Patient Identification:
Photo I.D.
Other: ______________________
POA Provided

PATIENT ☐ Received ☐ Refused a copy of this form ☐ Verbal Request: ______________________

Information released to: ______________________ Date: ________ Time: ________

Information released by: ______________________ Date: ________ Time: ________

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MEDICAL INFORMATION RELEASE

PATIENT NAME: ____________________

DATE OF BIRTH: ____________________

PHYSICIAN NAME: ____________________
ADDRESS: ____________________
PHONE: ____________________
DATE OR DATE RANGE OF RECORDS: ____________________
RECORDS NEEDED BY: ____________________

PHYSICIAN NAME: ____________________
ADDRESS: ____________________
PHONE: ____________________
DATE OR DATE RANGE OF RECORDS: ____________________
RECORDS NEEDED BY: ____________________

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PHYSICIAN NAME: ____________________
ADDRESS: ____________________
PHONE: ____________________
DATE OR DATE RANGE OF RECORDS: ____________________
RECORDS NEEDED BY: ____________________

YOUR AUTHORIZED SIGNATURE AND DATE
MUST BE PROVIDED ON FIRST PAGE OF RELEASE