St Luke's
UNIVERSITY HEALTH NETWORK

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: ***If requesting hospital records please check off one of the below boxes and specify location.***

☐ Hospital Location(s): _____

☐ St. Luke's University Health Network: Entire Network Search

PRACTICE PROVIDER

SLPG PHYSICIAN OFFICES: ☐ **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?)

☐ Secure Email: _____

☐ Fax: _____

☐ Mailing Address: _____

☐ 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 default date range will be 10 years through date of request if no dates are listed.

The information to be released will cover the time from _____ to _____ (cannot be a future date)

☐ Record Summary (key documents from chart)
☐ Discharge Instructions (AVS)
☐ Emergency Room Record
☐ Office Notes/Visit Notes
☐ Immunizations
☐ History & Physical (H&P)
☐ Therapy Notes (PT, OT, Speech)
☐ Operative Reports
☐ Other: _____
☐ **Exception:** I do not give permission to release: _____

☐ Discharge Summary
☐ Consultation Reports
☐ Lab Reports
☐ X-Ray/Imaging Reports
☐ Radiology/Imaging on CD
☐ EKG, EEG, Stress Tests
☐ Vascular Studies

St Luke's
UNIVERSITY HEALTH NETWORK

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 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 and no longer protected by HIPAA.

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.

Patient/Authorized Person Signature	Print Name	Date	Time
Relationship	Unable to sign because		
Witness	Print Name	Date	Time
Witness	Print Name	Date	Time
Staff reviewing content with Patient/Authorized Person Signature	Print Name	Date	Time

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: _____