ROI Med Records Request

Saint Luke's

Print Form

Information Request - Patient Authorization

All sections of this authorization form MUST be completed to be valid in accordance with 42 CFR Parts 160 and 164

Patient Name:_____ Date of Birth: _____/_____/_____

Name at Time of Treatment (if different from above):_____

Address:_____ City:_____ State:_____ Zip Code:_____

E-mail Address:_____ Phone:_____

I request my records from:

- ☐ Allen County Regional Hospital
- ☐ Anderson County Hospital
- ☐ Bishop Spencer Place
- ☐ Crittenton Children's Center
- ☐ Hedrick Medical Center
- ☐ Saint Luke's Community Hospital
- ☐ Saint Luke's Cushing Hospital
- ☐ Saint Luke's East Hospital
- ☐ Saint Luke's Home Care & Hospice
- ☐ Saint Luke's Hospital of KC
- ☐ Saint Luke's North Hospital - Barry Road
- ☐ Saint Luke's North Hospital - Smithville
- ☐ Saint Luke's Regional Lab
- ☐ Saint Luke's South Hospital
- ☐ Wright Memorial Hospital

☐ Clinic:_____ ☐ Other:_____

I request my records to be sent to:

Name:_____ E-mail Address:_____

Address:_____ Phone:_____

City/State:_____ Zip Code:_____ Fax # (healthcare provider only):_____

What records do you want?

- ☐ Emergency Room Record
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Radiology film/tracing/media
- ☐ Office/Clinic Visits
- ☐ Detailed Billing
- ☐ Immunizations
- ☐ Other:_____

Covering the period of health care from:

☐ Specific Date(s):_____ to _____ **OR** ☐ All past, present and future encounters/visits

Purpose for requesting information (optional):

- ☐ Legal
- ☐ Insurance
- ☐ Personal
- ☐ Continuation of Care

How would you like your records delivered?

- ☐ Release to mySaintLuke's Patient Portal
- ☐ Paper ☐ Secure electronic delivery (will use above listed email)
- ☐ Other: Please Specify:_____

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- PHI may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management Department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition:_____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative Signature:_____ Date:_____ Time:_____

Printed name of authorized representative:_____ Relationship to patient:_____

Witness Signature:_____ Date:_____ Time:_____

If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form

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