



Request for Medical Records

# Saint Luke's Health System

## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**I request my protected health information (PHI) from:**

- Saint Luke's Hospital of KC
- Saint Luke's North Hospital - Smithville
- Saint Luke's Home Care & Hospice
- Saint Luke's East Hospital
- Saint Luke's North Hospital - Barry Road
- Saint Luke's Regional Lab
- Saint Luke's South Hospital
- Anderson County Hospital
- Saint Luke's Cushing Hospital
- Hedrick Medical Center
- Crittenton Children's Center
- Wright Memorial Hospital
- Clinic: \_\_\_\_\_
- Other: \_\_\_\_\_

**I request my protected health information (PHI) to be released to:**

Name: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**I authorize the following PHI to be released from my medical record(s):**

- Emergency Room Record
- Laboratory Report(s)
- Pathology Slides
- Complete Medical Record (all pages)
- Radiology Report(s)
- Detailed Billing
- Abstract/Hospital Summary (transcribed reports/lab/radiology)
- Radiology film/tracing/media
- 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 information is to be received**

- Patient Portal
- Fax (to healthcare provider only)
- E-mail – secure format
- CD – secure electronic format
- US Mail – paper format

**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**