ROI Med Records Request

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: _____/_____/_____

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

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

E-mail Address:_____ Phone:_____

I request my records from:

☐ Anderson County Hospital ☐ Saint Luke's Cushing Hospital ☐ Saint Luke's North Hospital - Smithville
☐ Bishop Spencer Place ☐ Saint Luke's East Hospital ☐ Saint Luke's Regional Lab
☐ Crittenton Children's Center ☐ Saint Luke's Home Care & Hospice ☐ Saint Luke's South Hospital
☐ Hedrick Medical Center ☐ Saint Luke's Hospital of KC ☐ Wright Memorial Hospital
☐ Saint Luke's Community Hospital ☐ Saint Luke's North Hospital - Barry Road
☐ 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 ☐ Laboratory Report(s) ☐ Office/Clinic Visits
☐ Discharge Summary ☐ Radiology Report(s) ☐ Detailed Billing
☐ Operative Report ☐ Radiology film/tracing/media ☐ 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