St. Luke's
915 East First Street
Duluth, MN 55805

For office use only:
Request # _____
VS _____
Completed by _____
Date _____

Patient Name: LAST _____ FIRST _____ MI _____ Date of Birth _____ Medical Record Number _____

I hereby authorize:
(Name and address of releasing facility)

_____
_____
_____
_____

To release information to:
(Individual name, facility/organization and address)

_____
_____
_____
_____

PURPOSE OF DISCLOSURE
( ) Continuing Care
( ) Payment of Claim
( ) School
( ) Worker's Compensation
( ) Legal
( ) For Personal Use
( ) Other (specify): _____

INFORMATION TO BE RELEASED: Between Dates of: _____ and _____

( ) Discharge Summary	_____	( ) X-Ray Reports	_____
( ) H&P Exam/Initial Evaluation	_____	( ) X-Ray Films/MRI	_____
( ) Consultation Report	_____	( ) Diagnostic Test Reports	_____
( ) Counselor/Therapist Summary	_____	( ) Procedure Reports	_____
( ) Progress Notes/Provider Notes	_____	( ) Lab Reports/Pathology	_____
( ) Orders	_____	( ) Correspondence	_____
( ) ER/Urgent Care/QCare	_____	( ) Itemized Billing Statement	_____
( ) Condition Report	_____		

( ) Other (Specify content/dates): _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one year after the date signed.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that in compliance with MN Statute 144.292 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand that my medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse.
- Psychotherapy notes will not be released per facility policy and HIPAA privacy rules, 45 CFR Parts 160 and 164, 164.502.

_____ _____ _____ _____
Signature of patient, parent of minor, or personal representative Relationship Date Phone

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION