St. Luke's
915 East First Street
Duluth, MN 55805
(218) 249-2003/(218) 249-3076 (fax)

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

I hereby authorize:

Check one or both:

☐ St. Luke's Hospital
☐ St. Luke's Clinics
Specify clinics using attached list.
Information from ALL St. Luke's Clinics will be released if clinics are not specified.

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	_____

( ) Other (Specify content and dates): _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one year.
- 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

_____ Bay Area Health Center

_____ Chequamegon Clinic

_____ Denfeld Medical Center

_____ Duluth Internal Medicine Associates

_____ Hibbing Family Medical Center

_____ Laurentian Medical Clinic

_____ Lester River Medical Clinic

_____ Mariner Medical Clinic

_____ Miller Creek Medical Clinic

_____ Mount Royal Medical Clinic

_____ P.S. Rudie Medical Clinic

_____ Q Care St. Luke's Express Clinic

_____ St. Luke's Allergy and Immunology

_____ St. Luke's Cardiothoracic Surgery Assoc.

_____ St. Luke's Cardiology Associates

_____ St. Luke's Dermatology

_____ St. Luke's Neurosurgery Associates

_____ St. Luke's Physical Medicine and Rehab

_____ St. Luke's Endocrinology

_____ St. Luke's Gastroenterology

_____ St. Luke's Infectious Disease

_____ St. Luke's Internal Medicine

_____ St. Luke's Mental Health

_____ St. Luke's Obstetrics & Gynecology

_____ St. Luke's Occupational Health

_____ St. Luke's Oncology

_____ St. Luke's Ophthalmology

_____ St. Luke's Orthopedics

_____ St. Luke's Pavilion Surgery

_____ St. Luke's Pediatric Assoc.

_____ St. Luke's Plastic Surgery

_____ St. Luke's Pulmonary Medicine

_____ St. Luke's Radiation Oncology

_____ St. Luke's Rheumatology

_____ St. Luke's Surgical Associates

_____ St. Luke's Urgent Care

_____ St. Luke's Urology

1/2013