St Luke's
UNIVERSITY HEALTH NETWORK

☐ Allentown, Anderson, Bethlehem, Miners, Monroe,
Quakertown and Warren Campuses
77 South Commerce Way, Suite 100
Bethlehem, PA 18017
484-526-4719 Fax 484-526-4724

MEDICAL INFORMATION RELEASE

Encounter Number: _____ **Medical Record Number:** _____

Date/Time Request Received: _____

PATIENT NAME	DATE OF BIRTH
PATIENT ADDRESS	PHONE NUMBER

I authorize: _____ to release my Medical Records to: _____

☐ **For Continuation of Care**
☐ **For Personal Use**

Address: _____

- Is patient a minor? ☐ Yes ☐ No
- If Yes, are there any legal restrictions of your authority to act on behalf of the minor? ☐ Yes ☐ No
- If Yes, Legal documentation provided? ☐ Yes ☐ No

Appt. Date: _____
Phone/Fax: _____
Email Address: _____

ATTENTION PATIENT

I understand & authorize the release of this information unless noted below as exception.
I also understand that my record may contain:

- AIDS/HIV-Related Information, if AIDS/HIV-related tests were ordered by my physician; Confidentiality of HIV-Related Information Act, PA Law Act 148
- Mental Health Information, if mental health treatment was given by my physician; PA Mental Health Procedure Act
- Drug or Alcohol Information, if drug or alcohol tests were ordered or treatment provided by my physician. Drug & Alcohol Abuse Control Act 42 CFR Part 2; 71 P.S. 1690.108(c)

Date(s) of Service: _____

☐ **REQUESTED ON ELECTRONIC MEDIA**

☐ D/C Summary	☐ Consult	☐ CD/Film
☐ X-Ray Report	☐ H & P	☐ Other: _____
☐ Operative Report	☐ ED	_____
☐ EKG, EEG	☐ Vascular	_____
☐ Stress, ECHO	☐ Labs	_____

☐ **EXCEPTION: I do not give permission to release (please specify):** _____

I understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I acknowledge that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

I understand that I may revoke this authorization at any time, in writing, except to the extent that St. Luke's has already relied on it in making a disclosure. My written revocation will become effective when St. Luke's receives it. If I wish to revoke this authorization, I will send a written request to: St. Luke's University Health Network, Medical Records Department, 77 Commerce Way, Bethlehem, PA 18017.

I understand that my authorization will remain effective for a period of 90 days from date of my request.

_____ _____
Patient's Signature Date

_____ _____
Signature of Authorized Person Date

Relationship: _____

Unable to sign because: _____

Patient Identification:
Photo I.D.
Other: _____
POA Provided

PATIENT ☐ Received ☐ Refused a copy of this form ☐ Verbal Request: _____

Information released to: _____ Date: _____ Time: _____

Information released by: _____ Date: _____ Time: _____