St Luke's
UNIVERSITY HEALTH NETWORK

☐ Allentown, Bethlehem and Anderson Campuses
1510 Valley Center Parkway, Suite 240
Bethlehem, PA 18017
484-526-4719 Fax 484-526-4724

☐ Miners Memorial Campus
360 West Ruddle Street
Coaldale, PA 18218
570-645-8170 Fax 570-645-8373

☐ Quakertown Campus
1021 Park Avenue
Quakertown, PA 18951
215-538-4694 Fax 215-529-5299

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: _____

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

NAME OF DOCTOR/HOSPITAL/INSURANCE COMPANY/OTHER AGENCY

ATTENTION

ADDRESS AND/OR FAX # / PHONE #

FOR THE PURPOSE OF

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

Date(s) of Service _____

☐ **REQUESTED ON ELECTRONIC MEDIA**

☐ Consultation Report
☐ Discharge Summary
☐ EKG, EEG, Stress, ECHO
☐ Emergency Dept Records
☐ Face Sheet/Demographics Sheet
☐ Films/CD
☐ History & Physical
☐ Laboratory Results
☐ Operative Report
☐ X-Ray Report/CVL Report
☐ Other _____

☐ **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 sent a written request to: St. Luke's University Health Network, Medical Records Department, 1510 Valley Center Parkway, Suite 240, 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: _____