Request for Medical Records

Saint Luke's Health System **MRN** _____

Saintlukeshealthsystem.org ***Acct. No.***_____

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: _____/_____/_____

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

E-mail Address: _____ Phone: _____

I request my protected health information (PHI) from: Hospitals ↓ Clinics ↓

☐ Saint Luke's Hospital-Plaza	☐ Anderson County Hospital	☐ Saint Luke's Medical Group
☐ Saint Luke's East Lee's Summit	☐ Cushing Memorial Hospital	☐ Cabot Westside Health Center
☐ Saint Luke's South	☐ Hedrick Medical Center	☐ Saint Luke's Cardiovascular Consultants
☐ Saint Luke's Northland-Barry Road	☐ Wright Memorial Hospital	☐ Saint Luke's Neurological Consultants
☐ Saint Luke's Northland-Smithville	☐ Crittenton Children's Center	
☐ Saint Luke's Cancer Institute	☐ Saint Luke's Home Care & Hospice	☐ Saint Luke's Regional Lab

☐ Other: _____

I request my protected health information (PHI) to be released to:

Name: _____ E-mail Address: _____

Address:_____ Phone: _____

City/State:_____ Zip Code:_____ Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

☐ Emergency Room Record	☐ Laboratory Report(s)	☐ Pathology Slides
☐ Complete Medical Record (all pages)	☐ Radiology Report(s)	☐ Detailed Billing
☐ Abstract/Hospital Summary (dictated reports/lab/radiology)	☐ Radiology film/tracing/media	
☐ Other _____		

Covering the period of health care from:

☐ Specific Date(s): _____ to _____ **OR** ☐ All past, present and future encounters/visits

Purpose for requesting information:

☐ Legal	☐ Insurance
☐ Personal	☐ Continuation of Care

How information is to be received (if not marked, paper is default):

☐ US Mail – paper format	☐ Fax (to healthcare provider only)
☐ E-mail – secure format	☐ CD – secure electronic format

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

SYS-006 (Rev. 09/28/11)