|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  | For office use only: |  |
|  |  |  |  |  |  |  |  |  |  |  | Request # |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | VS |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | **915 East First Street** |  | Completed by |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  | **Duluth, MN 55805** |  | Date |  |  |  |
|  |  |  |  |  |  |  |
|  |  | **(218) 249-2003/(218) 249-3076 (fax)** |  |  |  |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Patient Name: LAST | FIRST | MI |  |  | Date of Birth |  | Medical Record Number |  |
| I authorize release from: |  |  |  |  |  | To release information to: |  |  |  |  |  |  |  |  |  |
| (Check all that apply) |  |  |  |  |  | (Individual name, facility/organization and address) |  |
|  | St. Luke’s Hospital |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | St. Luke’s Clinics |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Specify clinics using attached list. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Information from ALL St. Luke’s Clinics, excluding** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Mental Health, will be released if clinics are not specified.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Mental Health must be checked in order to release.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | St. Luke’s Mental Health Clinic |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ( | ) Verbal Discussion w/ Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| ( | ) 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**

**MR 19b Rev. 5/16**



|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_ | Bay Area Health Center | \_\_\_\_\_\_ St. Luke’s Gastroenterology |
| \_\_\_\_\_\_ | Chequamegon Clinic | \_\_\_\_\_\_ St. Luke’s Homecare & Hospice |
| \_\_\_\_\_\_ | Denfeld Medical Center | \_\_\_\_\_\_ | St. Luke’s Infectious Disease |
| \_\_\_\_\_\_ | Hibbing Family Medical Center | \_\_\_\_\_\_ St. Luke’s Internal Medicine |
| \_\_\_\_\_\_ | Laurentian Medical Clinic | \_\_\_\_\_\_ | St. Luke’s Medical Arts Clinic |
| \_\_\_\_\_\_ | Lester River Medical Clinic | \_\_\_\_\_\_ | St. Luke’s Mental Health |
| \_\_\_\_\_\_ | Mariner Medical Clinic | \_\_\_\_\_\_ St. Luke’s Obstetrics & Gynecology |
| \_\_\_\_\_\_ | Miller Creek Medical Clinic | \_\_\_\_\_\_ | St. Luke’s Occupational Health |
| \_\_\_\_\_\_ | Mount Royal Medical Clinic | \_\_\_\_\_\_ St. Luke’s Oncology & Hematology |
| \_\_\_\_\_\_ | P.S. Rudie Medical Clinic | \_\_\_\_\_\_ St. Luke’s Ophthalmology |
| \_\_\_\_\_\_ | Q Care St. Luke’s Express Clinic | \_\_\_\_\_\_ St. Luke’s Orthopedics |
| \_\_\_\_\_\_ | St. Luke’s Allergy & Immunology | \_\_\_\_\_\_ St. Luke’s Pediatric Associates |
| \_\_\_\_\_\_ | St. Luke’s Cardiothoracic Surgery Assoc. | \_\_\_\_\_\_ | St. Luke’s Plastic Surgery |
| \_\_\_\_\_\_ | St. Luke’s Cardiology Associates | \_\_\_\_\_\_ St. Luke’s Pulmonary Medicine |
| \_\_\_\_\_\_ | St. Luke’s CDI/MRI | \_\_\_\_\_\_ St. Luke’s Radiation Oncology |
| \_\_\_\_\_\_ | St. Luke’s Dermatology | \_\_\_\_\_\_ St. Luke’s Rheumatology |
| \_\_\_\_\_\_ | St. Luke’s Neurosurgery Associates | \_\_\_\_\_\_ | St. Luke’s Surgical Associates\* |
| \_\_\_\_\_\_ | St. Luke’s Physical Medicine & Rehab | \_\_\_\_\_\_ St. Luke’s Urgent Care |
| \_\_\_\_\_\_ St. Luke’s Endocrinology | \_\_\_\_\_\_ St. Luke’s Urology |

\*For information from Pavilion Surgery Center, call (218)279-6200.