St. Luke's Cataract & Laser Institute
"Excellence... with love"

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Toll Free (800) 282-9905
Fax (727) 943-3325

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT:

Name _____ Chart # _____

Address _____

City _____ State _____ Zip _____

Phone # _____

Date of Birth _____ Social Security # _____

INFORMATION TO BE DISCLOSED: Three years of medical records will be provided unless otherwise requested.

☐ All Records ☐ Office Notes ☐ Photos ☐ Lab & X-Ray ☐ Consultation Report
☐ Procedure Reports ☐ Topography ☐ US ☐ Visual Field ☐ Substance Abuse
☐ HIV ☐ Psychiatric Care ☐ Other, specify _____

PURPOSE OF DISCLOSURE:

☐ Continuing Care ☐ Personal Copy

DISCLOSE INFORMATION FROM: * Please provide complete mailing address *

_____
Name of Doctor / Hospital / Clinic

_____
Address City State Zip

_____ _____
Telephone Number Fax Number

SEND TO: *We will be unable to send your medical records unless the COMPLETE MAILING ADDRESS is provided.*

_____
Name of Doctor / Hospital / Clinic / Patient

_____
Address City State Zip

_____ _____
Telephone Number Fax Number

I understand that:

- This authorization is valid for 90 days after receipt.
- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it.

I hereby authorize St. Luke's Cataract & Laser Institute/St. Luke's Surgical Center, Inc. to release medical, psychiatric, alcohol and/or drug abuse, HIV testing, or any other records of a sensitive nature.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient or Patient's Representative

_____
Relationship to Patient or Legal Authority (attach supporting documentation)

For Office Use:
Person Sending Records:

_____

Date: _____

# of Pages Released:

_____

Mailed Faxed Picked Up