St. Luke's CATARACT & LASER INSTITUTE
"Excellence...with love"

St. Luke's SURGICAL CENTER, INC.
"Excellence...with love"

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

SECTION A: I authorize the disclosure of my personal health information as described in Section B below. I understand this authorization is voluntary and made to confirm my directions.

I hereby give my permission to **St. Luke's Cataract Laser Institute and/or St. Luke's Surgical Center, Inc.** to disclose my personal health information in the manner described herein.

Patient Name:______________________________

Address: ______________________________

Telephone: ____________________ Chart #: ____________________

SECTION B: Personal Health Information to Be Disclosed: Describe the type of personal health information you are authorizing to be used and/or disclosed:

☐ Medical and Financial Information

☐ Other Information:______________________________

Persons/Entities Authorized to Receive and Use: Name or specifically describe the persons and/or entities to which you are authorizing us to disclose or let use the personal health information described above:
Name:____________________ Relationship to Patient:____________________

Purpose of the Disclosure: The disclosure of Personal Health Information is being released for the following reason: ______________________________

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke the authorization, I will submit a request in writing.

Expiration: This authorization shall remain in force for a period of 5 years after the last patient encounter unless revoked by me in writing.

SIGNATURE: I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction. I understand that, by signing this form, I am confirming my authorization that personal health information may be used and/or disclosed to the persons and/or organizations named in this form.

Patient Signature: ____________________ Date: ____________________

Witness Signature: ____________________ Date: ____________________

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
NOTICE TO RECIPIENT OF INFORMATION:

This information has been disclosed to you from records the confidentiality of which may be protected by Federal and/or State Law. If the records are so protected, Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.