St. Luke's Cataract & Laser Institute — Life Changing Vision®
St. Luke's Surgical Center, Inc. — Life Changing Vision®
43309 US Hwy 19 N. | Tarpon Springs, FL 34689
800-282-9905 • 727-938-2020 • Fax: 727-938-5606
StLukesEye.com

St. Luke's at The Villages — Life Changing Vision®
St. Luke's Surgical at The Villages
1050 Old Camp Road, Bldg #230 | The Villages, FL 32162
800-282-9905 • 352-350-8484 • Fax: 352-751-9850
StLukesAtTheVillages.com

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

Delivery Preference for Personal Copy:

☐ Email (preferred email) _____
☐ Physical Copy ($15 shipping fee applies)

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, P.A. / St. Luke's Surgical Center, Inc. / St. Luke's at The Villages, P.A. / St. Luke's Surgical at The Villages, 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