ASPIRUS ST. LUKE'S

915 E. 1st Street | Duluth, MN 55805

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:	Last Name: _____ First Name: _____ Date of Birth: _____	
I HEREBY AUTHORIZE:	Name: _____ Address: _____ City: _____ State: _____ Zip: _____	
TO RELEASE INFORMATION TO:	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Fax (patient care only): _____	
PURPOSE OF DISCLOSURE:	( ) Continuing Care ( ) Payment of Claim ( ) School ( ) Worker's Compensation ( ) Legal ( ) Personal Use ( ) Other (specify): _____	**RELEASE METHOD:** ( ) Mail ( ) Fax (patient care only) ( ) Pick-up ( ) Email: _____
DATE INFORMATION IS NEEDED:	_____ (Note: Please allow 7-10 days for processing)	
INFORMATION TO BE RELEASED:	Between dates of: _____ and _____	
	Routine Record Set: ( ) Abstract (Provider Notes, Procedure Reports, H&P Exam, Discharge Summary, Radiology/Diagnostic Reports, Lab Reports)	
	( ) Discharge Summary ( ) H&P Exam/Initial Evaluation ( ) Consultation Report ( ) Rehab Records (PT/OT/ST) ( ) Progress Notes/Provider Notes ( ) Condition Report	( ) Orders ( ) ER/Urgent Care/QCare/eCare ( ) Radiology/MRI Reports ( ) Radiology/MRI Films ( ) Diagnostic Test Reports ( ) Other (specify content/dates): _____
		( ) Procedure Reports ( ) Lab/ Pathology Reports ( ) Immunization Records ( ) Itemized Billing Statement ( ) Verbal Discussion w/ Provider

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 or legally authorized representative	Relationship	Date/Time	Phone
_____	_____	_____	_____