St. Luke's 915 E. 1st Street, Duluth, MN 55805 | Phone: 218.249.2003 | Fax: 218.249.3076 Lake View

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:	Last Name: _____ First Name: _____ Date of Birth: _____
I AUTHORIZE RELEASE FROM:	( ) St. Luke's Hospital ( ) St. Luke's Pavilion Surgery Center ( ) St. Luke's Clinic(s) ( ) Lake View Hospital ( ) St. Luke's Mental Health Clinic ( ) Lake View Clinic(s)
Records from ALL clinics, excluding Mental Health, will be released if clinics are not specified on the attached list. Mental Health must be checked in order to release.	
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 ( ) Orders ( ) Procedure Reports ( ) H&P Exam/Initial Evaluation ( ) ER/Urgent Care/QCare/eCare ( ) Lab/Pathology Reports ( ) Consultation Report ( ) Radiology/MRI Reports ( ) Immunization Records ( ) Rehab Records (PT/OT/ST) ( ) Radiology/MRI Films ( ) Itemized Billing Statement ( ) Progress Notes/Provider Notes ( ) Diagnostic Test Reports ( ) Verbal Discussion w/ Provider ( ) Condition Report ( ) Other (specify content/dates): _____

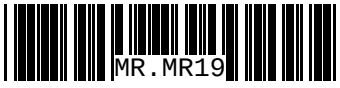
ACKNOWLEDGEMENT OF UNDERSTANDING:

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

For facility use only: MRN: _____ Request #: _____ Completed by: _____ Date: _____

MR 19b Rev. 6/20



St. Luke's Lake View

_____ Chequamegon Clinic

_____ Denfeld Medical Clinic

_____ Hibbing Family Medical Clinic

_____ Laurentian Medical Clinic

_____ Lake View Medical Clinic

_____ Lake View Silver Bay Medical Clinic

_____ Lester River Medical Clinic

_____ Mariner Medical Clinic

_____ St. Luke's Medical Arts Clinic

_____ Miller Creek Medical Clinic

_____ Mount Royal Medical Clinic

_____ P.S. Rudie Medical Clinic

_____ Q Care St. Luke's Express Clinic

_____ St. Luke's Allergy & Immunology

_____ St. Luke's Advanced Wound Care & Hyperbaric Center/Ostomy & Continence

_____ St. Luke's Cardiology Associates

_____ St. Luke's Cardiothoracic Surgery Associates

_____ St. Luke's Dermatology Associates

_____ St. Luke's Ear, Nose, & Throat Associates

_____ St. Luke's Endocrinology Associates

_____ St. Luke's Gastroenterology Associates

_____ St. Luke's Homecare & Hospice

_____ St. Luke's Infectious Disease Associates

_____ St. Luke's Internal Medicine Associates

_____ St. Luke's Mental Health

_____ St. Luke's Neurology Associates

_____ St. Luke's Neurosurgery Associates

_____ St. Luke's Obstetrics & Gynecology Associates

_____ St. Luke's Occupational Health Clinic

_____ St. Luke's Oncology & Hematology Associates

_____ St. Luke's Ophthalmology Associates

_____ St. Luke's Orthopedics & Sports Medicine

_____ St. Luke's Pediatric Associates

_____ St. Luke's Physical Medicine & Rehab Associates

_____ St. Luke's Plastic Surgery Associates

_____ St. Luke's Pulmonary Medicine & Rehab Associates

_____ St. Luke's Radiation Oncology Associates

_____ St. Luke's Rheumatology Associates

_____ St. Luke's Surgical Associates

_____ St. Luke's Urgent Care

_____ St. Luke's Urology Associates

_____ St. Luke's Vascular Surgery Associates