St. Luke's Medical, PC
3413 Wilmington Road
New Castle, PA 16105
T-724-656-9005
F-724-656-9003

Authorization for Disclosure of Protected Health Information (PHI)

Patient Name:		Date of Birth:
Full Address: Street/City/State/Zip Code		
Telephone Number:	Alternate Phone Number:	SS Number:

I authorize St. Luke's Medical, PC to disclose, obtain, or exchange Protected Health Information:

From: _____
_____
_____
_____

To: St. Luke's Medical, PC
3413 Wilmington Rd
New Castle, PA 16105

Purpose of Disclosure: _____

Please check specified sections needed:

Entire Medical Record	Lab Reports	Consultations	Pathology Report
Discharge Summary	X-ray Reports	ER Records	Orders
Progress Notes	Operative Reports	CT/MRI Reports	EKG
Medication Records	History and Physical	Other: _____	

Covering the period(s) of care: ____/_____/_____ through ____/_____/_____
(if Entire Medical Record was not selected)

Authorization and Waiver:

I hereby authorize St. Luke's Medical, PC to disclose the health information described above.

I understand that my medical record may contain information (including medications) related to alcohol/drug abuse and/or dependence, mental health/rehabilitation, HIV and/or AIDS, and/or sexual assault. This is information will be released unless I specify that the information should **NOT** be disclosed by initialing below:
____ Alcohol/Drug Abuse and/or Dependence ____Mental Health/Rehabilitation ____HIV and/or AIDS ____ Sexual Assault

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and present my written revocation to the Practice Privacy Officer, Mar Paras. If personal delivery is not possible the revocation must be mailed certified with delivery confirmation to the practice named in the letterhead above. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire 90 days from the date on which it was signed. I understand that the information disclosed according to this release may be re-disclosed by the recipient and is no longer protected by HIPAA Federal Regulation.

I understand that federal and state laws allow a fee to charged for the copying of patient records and i will be responsible for the payment of such fees.

I also release St. Luke's Medical,PC and its officers, trustees, agents and employees from any and all liabilities , damages and claims, which might arise from the release of the health information authorized by me above.

X_____ Date: _____/_____/_____
(Signature of Patient or Legal Representative)

Description of Authority to Act for Patient: _____