BAYLOR RADIOLOGISTS
a radiology partners affiliated practice

AUTHORIZATION TO INSPECT AND RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **BIRTHDATE:** _____

ADDRESS: _____ **PHONE: (H)** _____

_____ **(C)** _____

_____

1. I hereby authorize ***CHI St. Luke's Health*** to:

☐ Disclose/Release the specified health information:

TO: _____

_____

_____

_____

_____

Telephone No: (_____) _____

Fax No: (_____) _____

☐ Receive the specified health information:

FROM: _____

_____

_____

_____

_____

Telephone No: (_____) _____

Fax No: (_____) _____

2. The following health information to be disclosed is maintained in the designated record set: (specify the exact information to be disclosed, including dates of service):

☐ Complete Medical Record
[OR the records marked below]

Dates of Service: _____

- ☐ Emergency Department Record
- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Report of procedure
- ☐ Pathology Report
- ☐ OTHER (Specify): _____

_____

- ☐ Heart Diagram
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ Physician's Orders
- ☐ Nursing Notes

☐ Diagnostic films/Digital Images (Specify): _____

☐ Billing Records (Specify): _____

3. For the purpose of: _____

4. If you are requesting copies of your own medical record, indicate here if you would prefer to receive them on a password protected CD/DVD ☐ Yes ☐ No

5. I understand that this information may include information relating to specific laboratory tests of HIV infection (Human Immunodeficiency virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; treatment of drug or alcohol abuse, mental or behavioral health or psychiatric care, excluding psychotherapy notes.

BAYLOR RADIOLOGISTS
a radiology partners affiliated practice

6. I understand that ***CHI St. Luke's Health*** may charge a fee for the costs associated with processing this request.

7. ***CHI St. Luke's Health*** may deny this request to inspect and copy health information in certain limited circumstances, which are described in separate policies. If you are denied access, you may request that the denial be reviewed. Another licensed health care professional chosen by ***CHI St. Luke's Health*** will review your request and the denial. The person conducting the review will not be the person who denied the request. ***CHI St. Luke's Health*** will comply with the outcome of the review.

   This authorization is given freely with the understanding that:

   a) I may revoke this authorization at any time, except where information has already been released.
   b) The revocation must be in writing and a form is available from the medical record department.
   c) This authorization will expire in **180 days** from the date of signature unless otherwise specified; expires: _____
   d) ***CHI St. Luke's Health*** may not condition treatment or payment upon obtaining this authorization.
   e) A photocopy or fax of this authorization is as valid as the original.
   f) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ *Signature of Patient*

_____ *Date*

_____ *Signature of Patient's Representative*

_____ *Representatives Printed Name*

_____ *Relationship to Patient*

_____ *Date*

CHI St. Luke's Health STAFF

☐ **Verified identity of person picking up records.**

Date Verified: _____ **Name: _____**

Department: _____

To be Completed by Areas Other Than Hospital Information Management

Date authorization received: _____

Date information released: _____

Name and title of CHI St. Luke's Health Staff member processing request:

_____

After processing request, please forward Authorization form to the Health Information Management Department.