Rockhill Orthopaedic Specialists

Saint Luke's East - Lee's Summit Campus
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Saint Luke's HEALTH SYSTEM

MEDICAL RECORDS RELEASE FORM

All sections of this authorization form MUST be completed to be valid in accordance with 42 CFR Parts 160 and 164

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

E-mail Address: _____ **Phone:** _____

I request my protected health information (PHI) from:

☐ **Rockhill Orthopaedic Specialists** ☐ **Other:** _____

I request my protected health information (PHI) to be released to:

Name: _____ **E-mail Address:** _____

Address: _____ **Phone:** _____

City/State: _____ **Zip Code:** _____ **Fax# (healthcare provider only):**

I authorize the following PHI to be released from my medical record(s):

☐ **Complete Medical Record (all pages)** ☐ **Laboratory Report(s)** ☐ **Radiology films/images**
☐ **Progress/Office Note(s)** ☐ **Work Status Report(s)** ☐ **Radiology Report(s)**
☐ **Operative Report(s)** ☐ **Medication Listing** ☐ **Detailed Billing**
☐ **Other:** _____

Purpose for requesting information (optional):

☐ **Legal** ☐ **Insurance**
☐ **Personal** ☐ **Continuation of Care**

How information is to be received:

☐ **Email - secure format** ☐ **Fax - to healthcare provider only**
☐ **US Mail - paper format** ☐ **CD - secure electronic format**

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- PHI may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management Department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____
  If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative Signature: _____ Date: _____ Time: _____

Printed name of authorized representative: _____ Relationship to patient: _____

Witness Signature: _____ Date: _____ Time: _____

If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.