St. Luke's Hospital
A Sutter Health Affiliate

Authorization for Use or Disclosure of Patient Health Information

St. Luke's Hospital
3555 Cesar Chavez Street
San Francisco, CA 94110
(Tel) 415-641-6515
(Fax) 415-641-6735

EXPLANATION: This authorization for use or disclosure of my health information is required by state and federal law.

(1) AUTHORIZATION:

I, *(Patient or Legal Representative)* _____ hereby authorize the use or disclosure of my health information as follows:

- ☐ St. Luke's Hospital
- ☐ Other (specify): _____

is authorized to use or disclose, and the following persons or entities are authorized to receive my protected health information *(name and address of recipients)* :

Name:					
Address:					
City:		State:		Zip:	
Phone:					

This authorization applies to health information pertaining to:

Patient's Name: _____ Date of Birth: _____ SS# _____

Patient's Medical Record #: _____ Date(s) of Service: _____

This authorization applies to the following information *(please check (✓) information to be disclosed)*:

☐ Discharge Summary	☐ Physical Therapy	
☐ Progress Notes	☐ Emergency Record	☐ Complete Medical Record
☐ History & Physical	☐ Laboratory Test(s)	☐ Other: _____
☐ Operative Report	☐ Radiology Report(s)	_____
☐ Consultation Report	☐ Pathology Report(s)	_____

Please include restricted access information relating to *(initial if needed)*:

_____ AIDS/HIV _____ Alcohol/drug abuse treatment _____ Mental Health Treatment *

*(*For disclosure of Mental Health Information, see section 6 below; a separate authorization is required to authorize the use or disclosure of psychotherapy notes.)*

The recipient may use my health information only for the following purposes: _____

_____

(2) EXPIRATION: This authorization shall become effective immediately and shall remain in effect until *(enter specific date or event)* : _____

(3) RESTRICTIONS: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

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(4) YOUR RIGHTS:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: 3555 Cesar Chavez St., San Francisco, CA 94110.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization; the original of this document will be placed in my medical record.
- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
- If this box ☐ is checked, St. Luke's will receive compensation for the use or disclosure of my health information.

(5) SIGNATURE:

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient if signed by someone other than patient: _____

Witness: _____

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(6) If the health information requested pertains to mental health information:
The undersigned physician, licensed psychologist, or social worker with a master's degree in social work who is in charge of the patient, hereby: ☐ Approves ☐ Disapproves the disclosure of information and records described herein. If disclosure is disapproved, give reasons below. Also note below any restriction, if any, on approved release of information.

_____

_____

Physician/Psychologist/Social Worker_____ Date: _____

Applicable Fees:	Clerical	Copying	Delivery
Delivered to a Health Care Provider	No Fee	No Fee	No Fee
Delivered directly to Patient	No Fee	$0.25/page	Mailing Cost
Delivered to non-provider (3rd party)	$15.00	$0.25/page	Mailing Cost