CHI St. Luke's Health

AUTHORIZATION TO INSPECT AND RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ **BIRTHDATE:**_____

ADDRESS: _____ **TELEPHONE NO: (_____)_____**

_____

_____

1. I hereby authorize St. Luke's Health System (St. Luke's) to:

❑ Disclose/release the specified health information:

TO: Stem Cell Center
The Texas Heart Institute
Attn: Patient Recruitment
6770 Bertner Ave. MC 2-255
Houston, TX 77030
Telephone No: (832) 355-9802
Fax No: (832) 355-9440

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 Dates of service_____
[OR the records marked below]

- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Report of Procedure
- ☐ Pathology Report
- ☐ Heart Diagram
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ Physicians' Orders
- ☐ Nursing Notes
- ☒ OTHER

(specify)
- Most recent echocardiogram
- Most recent nuclear stress test
- Most recent history and physical
- Most recent ECG
- Most recent cardiac catheterization report
- Most recent lab work

☐ Diagnostic films/Digital Images (specify) _____

☐ Billing Records (specify)_____

☐ Marketing (Specify)_____

3. For the purpose of: _____

(OVER)

4. 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 for drug or alcohol abuse; mental or behavioral health or psychiatric care, excluding psychotherapy notes.

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

6. St. Luke's 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 St. Luke's will review your request and the denial. The person conducting the review will not be the person who denied the request. St. Luke's will comply with the outcome of the review.

7. 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 180 days from date of signature unless otherwise specified; expires _____.
d) St. Luke's 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

_____
Signature of Patient's Representative

_____
Date

_____
Representative's Printed Name

_____
Relationship to Patient

_____
Date

These Sections for St. Luke's Use Only

Date authorization received: _____
Request denied: _____No _____Yes {If yes, proceed to Denial Section}
Date information released: _____
Name and title of St. Luke's staff member processing request: _____. After processing request, please forward Authorization form to Medical Record Department.

DENIAL SECTION {for use only if Request Denied}

Reason for denial_____
Denial of request communicated to patient or patient representative on [date]_____by [Name and title of St. Luke's staff member]_____