

Release of Protected Health Information

800 East Park Boulevard Boise, Idaho 83712

Please use this form to give St. Luke's Health Plan the right to use and disclose your personal, private health information (PHI) to the extent permitted by law.

Membe	r (the person wh	nose information	is being release	d):		
II Name:				DOB:		
i ivallie	Last	First	M.I.	DOB		
dress:	Street Address				Apartm	nent/Unit #
	City		State		Zip Code	
one:		N	Member ID:		·	
The per	son(s) or entity	to whom PHI can	be disclosed:			
l Name:	Last	First		DOB:		
			M.I.			
dress:	Street Address				Apartm	ent/Unit #
	City		State		Zip Code	
one:		N	Member ID:			
Descrip	tion of informat	ion to be used or	disclosed:			
ne of infe						
pe or into	ormation:					
All psychoth	nerapy notes about me	maintained by St. Luke's	Health Plan			
Any psycho	therapy notes pertainin	g to the following topic(s):			
All psychoth	nerapy notes about me	for dates between	and			
All psychoth	nerapy notes about me	pertaining to	betwe	en	(date) and	(date)

 $\textbf{Note:} \ \textbf{Items not checked above will not be used or disclosed, unless permitted by law}$

The purpose of the requested disclosure: At my request* Personal use Continued medical care Insurance claim Insurance application Social Security/Disability determination Military School Other (please specify) Legal purposes * This option is the sufficient description when an individual initiates the authorization and does not, or elects not to, provide a statement of purpose. **Expiration date:** This authorization shall remain valid (unless revoked in writing) until: One year from the date I sign it The following date: _____ Until the following event occurs: _____ Signature By signing below, I acknowledge understanding that: I may revoke this authorization at any time in writing, and upon request, St. Luke's Health Plan will furnish me with a form to make my written revocation, but I am not required to use that form to make my written request for revocation. My revocation will not apply to the information that has already been released as permitted by this authorization. St. Luke's Health Plan may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. The person(s) to whom this information is disclosed may re-disclose the information, and it will no longer be protected by federal health information privacy law. I have a right to request and receive a copy of this authorization. I have read and understand this Authorization for Release Protected Health Information (PHI), I have signed the form voluntarily and have received a copy of it: Name: _____

Signature:

Relationship to member:

Verification (Internal Use Only)

Identity of individual verified

Identity of Representative and their authority to act verified

Received and confirmed for St. Luke's Health Plan by:

Signature:	Date:	
Name of employee:		

Email the form to customerservice@slhealthplan.org. For questions, call 833-840-3600.