St Luke's™ Health Plan

800 East Park Boulevard
Boise, Idaho 83712

Release of Protected Health Information

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.

Member (the person whose PHI is being used or disclosed):

Full Name: _____ DOB: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Phone: _____ Member ID: _____

The person(s) or entity to whom PHI can be disclosed:

Full Name: _____ DOB: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Phone: _____ Member ID: _____

The purpose of the requested disclosure:

- ☐ At my request*
- ☐ Continued medical care
- ☐ Insurance application
- ☐ Military
- ☐ Legal purpose

*This option is the sufficient description when an individual initiates the authorization and does not, or elects not to, provide a statement of purpose.

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Information to be used or disclosed:

Please check the box describing the PHI you are requesting to be used or disclosed. If none of the options below apply, please check "Other" and provide a brief description.

- ☐ All health information
- ☐ Laboratory reports
- ☐ Pathology reports
- ☐ Medication records
- ☐ Test reports
- ☐ Discharge summary
- ☐ Imaging reports (X-ray)
- ☐ Other (specify): _____
- ☐ History and physical
- ☐ Itemized billing statement

Note: Items not checked above will not be used or disclosed, unless permitted by law.

Sensitive information to be used or disclosed:

I understand that my records may contain information related to history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment, and genetic information. If my records contain any such information, I authorize the use or disclosure of that information as follows (select all that apply):

- ☐ HIV or AIDs
- ☐ Mental illness or psychiatric treatment
- ☐ Sexually transmitted infections or testing
- ☐ Genetic information
- ☐ Drug and/or alcohol abuse
- ☐ Other (specify): _____

Note: Items not checked above will not be used or disclosed, unless permitted by law.

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:

1. 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.
2. My revocation will not apply to the information that has already been released as permitted by this authorization.
3. St. Luke's Health Plan may not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
4. 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.
5. I have a right to request and receive a copy of this authorization.

I have read and understand this Authorization for Release of 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: _____ (Employee name)

Signature: _____ Date: _____

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