ROI Med Records Request

Saint Luke's Health System

Information Request – Patient Authorization

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: ____/____/____

Name at Time of Treatment (if different from above):________________

Address:________________ City:________ State:____ Zip Code:________

E-mail Address:________________ Phone:________________

I request my records from:

☐ Anderson County Hospital ☐ Saint Luke's Cushing Hospital ☐ Saint Luke's North Hospital - Smithville
☐ Bishop Spencer Place ☐ Saint Luke's East Hospital ☐ Saint Luke's Regional Lab
☐ Crittenton Children's Center ☐ Saint Luke's Home Care & Hospice ☐ Saint Luke's South Hospital
☐ Hedrick Medical Center ☐ Saint Luke's Hospital of KC ☐ Wright Memorial Hospital
☐ Saint Luke's Community Hospital ☐ Saint Luke's North Hospital - Barry Road
☐ Clinic:________________ ☐ Other:________________

I request my records to be sent to:

Name: Records Deposition Service E-mail Address: requests@recdep.com

Address: 29100 Northwestern Hwy., Ste. 300 Phone: (248) 357-3330

City/State: Southfield Zip Code: 48034 Fax # (healthcare provider only):________

What records do you want?

☐ Emergency Room Record ☐ Laboratory Report(s) ☐ Pathology Slides
☐ Complete Medical Record (all pages) ☐ Radiology Report(s) ☐ Detailed Billing
☐ Abstract/Hospital Summary (transcribed reports/lab/radiology) ☐ Radiology film/tracing/media
☐ Other:________________

Covering the period of health care from:

☐ Specific Date(s):__________ to __________ **OR** ☐ All past, present and future encounters/visits

Purpose for requesting information (optional):

☒ Legal ☐ Insurance
☐ Personal ☐ Continuation of Care

How would you like your records delivered?

☐ Paper (☐ Home Delivery or ☐ In Person Pickup)
☒ Electronic (Secure Email, Fax to Clinician, CD, Portal, other)

Please Specify: requests@recdep.com

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