

**Mercy Medical Center**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

<b>PATIENT IDENTIFICATION</b>	Name: _____ Last First M.I.
	Birth Date: _____ Social Security #: _____ Medical Record #: _____
	Address: _____ Street City State/Zip
	Telephone Number: _____ Home Other

<b>INFORMATION BEING SENT TO/FROM</b> (CHECK ONLY ONE)	<input type="checkbox"/> This information is to be released <b>FROM</b> Mercy Medical Center to the facility or individual specified below: _____ Name or facility or individual _____ Address _____ Initial to permit for fax release for immediate or emergency patient care needs _____ Fax Number	<input type="checkbox"/> This information is to be released <b>TO</b> Mercy Medical Center _____ Department Name from the facility or individual specified below: _____ Name or facility or individual _____ Address
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<b>TYPE OF INFORMATION BEING REQUESTED</b>	For date(s) of service: <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical Report <input type="checkbox"/> Emergency Room Report <input type="checkbox"/> Laboratory Report <input type="checkbox"/> X-ray Report <input type="checkbox"/> Film <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Physical Therapy Report <input type="checkbox"/> Abstract "Summary" Data <input type="checkbox"/> Other (Specify) _____
	<b>**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FUTURE PROTECTED BY STATE OR FEDERAL LAW**</b> <b>Initial any category to BE released:</b> _____ Acquired immunologic syndrome (AIDS) or human immunodeficiency virus (HIV) _____ Alcohol and drug abuse treatment _____ Behavioral or mental health services

<b>PURPOSE FOR DISCLOSURE</b>	<input type="checkbox"/> Patient Care <input type="checkbox"/> Personal Use <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Legal Review <input type="checkbox"/> Other _____
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<b>TIME LIMIT</b>	I understand that I may cancel (revoke) this authorization at any time by sending a written notice to Mercy's Health Information (Medical Records) department and that my cancellation will take effect when the written notice is received and it will not apply to information that has already been released in response to this authorization. This authorization will automatically expire six (6) months from the date of signature except as specified. (Specify expiration date, event, or condition: _____ )
	I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations unless otherwise prohibited from re-disclosure under other federal and/or state laws or regulations.

<b>SIGNATURE AND DATE</b> (A copy of this signed form will be provided to the patient.)	_____ Signature (Patient or Legal Representative)      Date _____ Relationship, if not the patient      Witness
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Information processed and sent (date and initials) \_\_\_\_\_

COPY MADE      Original - Medical Record      Copy - Patient



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