Mercy Medical Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

Name: _____
Last First M.I.

Birth Date: _____ Social Security #: _____
Optional − Last 4 digits only

Address: _____
Street City State/Zip

Telephone Number: _____ _____
Home Other

INFORMATION BEING SENT TO/FROM
(CHECK ONLY ONE)

☐ This information is to be released **FROM** 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

☐ This information is to be released **TO** Mercy Medical Center _____
Department Name
from the facility or individual specified below:

_____
Name or facility or individual

_____
Address

TYPE OF INFORMATION BEING REQUESTED

For date(s) of service: _____

☐ Discharge Summary
☐ Laboratory Report
☐ Pathology Report
☐ History & Physical Report
☐ X−ray Report ☐ Film
☐ Physical Therapy Report
☐ Emergency Room Report
☐ Operative Report
☐ Abstract "Summary" Data

☐ Other (Specify) _____

****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FUTHER PROTECTED BY STATE OR FEDERAL LAW****

Initial any category to BE released:

_____ Acquired immunologic syndrome (AIDS) or human immunodeficiency virus (HIV)
_____ Alcohol and drug abuse treatment
_____ Behavioral or mental health services

PURPOSE FOR DISCLOSURE

☐ Patient Care
☐ Insurance Claim
☐ Other _____
☐ Personal Use
☐ Legal Review

TIME LIMIT

I understand that I may cancel 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 redisclosed and no longer protected by federal privacy regulations unless otherwise prohibited from redisclosure under other federal and/or state laws or regulations.

SIGNATURE AND DATE
(A copy of this signed form will be provided to the patient.)

_____ _____
Signature (Patient or Legal Representative) Date

_____ _____
Relationship, if not the patient Witness

Photo ID Checked ☐ Information processed and sent (date and initials) _____