AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

Name: _____
LAST FIRST M.I.

Birth Date: _____ **Male/Female:** _____ **SS#:** _____
Optional-last 4 digits

Address: _____
Street City State/Zip

Telephone Number: _____ _____
Home Other

INFORMATION BEING SENT TO/FROM (CHECK ONE ONLY)

☐ This information is to be released **FROM** Mercy Medical Center to the facility or individual specified below:

_____
Name or Facility or individual

_____
Street City State/Zip

Phone: _____

Fax: _____

_____ **Initial to permit for fax release for immediate or emergency patient care needs**

☒ This information is to be released **TO** Mercy Medical Center:

Mercy Pediatric Clinic
701 10th St SE, Cedar Rapids, IA 52403
Fax: 319-861-7950
From the facility or individual below:

_____
Name or facility or individual

_____
Street City State/Zip

Phone: _____

Fax: _____

TYPE OF INFORMATION BEING REQUESTED

For date(s) of service: ALL RECORDS

☐ Discharge Summary ☐ History & Physical Report ☐ Emergency Room Report
☐ Laboratory Report ☐ X-ray Report ☐ Film ☐ Operative Report
☐ Pathology Report ☐ Phyiscal Therapy Report ☐ Abstract "Summary" Data
☐ Other (Specify) _____

PLEASE NOTE: There may be a charge associated with copies of Medical Record

****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER 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 ☐ Personal Use
☐ Insurance Claim ☐ Legal Review
■ Other **TRANSFER OF RECORDS**

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

_____ _____
Signature (Patient or Legal Representative) Date

_____ _____
Print name Relationship, if not the patient

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

999-50022 04/16 070262
AUTH REL
AUTHORIZATION FOR RELEASE OF

MERCY CEDAR RAPIDS
Original – Medical Record

Patient Account #: _____

Patient Unit #: _____