Mercy Medical Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Mercycare Service Corporation
701 10th Street SE, Cedar Rapids, IA 52403
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PATIENT IDENTIFICATION **List previous names (maiden, married, legal changes)**	Name: ______________ (Last) ______________ (First) ______ (MI) Previous Names (maiden, married, etc.): ______________ Birth Date: ______________ Social Security # ______________ (Optional - Last 4 digits only) Address: ______________ (Street) ______________ (City / State / Zip Code) Phone #'s: ______________ Alternate #: ______________ Email (optional): ______________
INFORMATION BEING SENT TO/FROM (CHECK ONLY ONE) Requested Format: ☐ Mail ☐ Fax: ______________ ☐ MyChart ☐ CD / USB (circle one) ☐ Email (email is not a secure means of communication Need by: ______________	☐ This information is to be released **FROM** Mercy Medical Center to the facility or individual specified below: ______________ Name and/or facility ______________ Address ______________ City / State / Zip Code ☐ Myself (at the Address Listed Above) ☐ Pickup ☐ Call When Ready ☐ This information is to be released **TO** Mercy Medical Center **Mercy Urology Clinic** from the facility or individual specified below: **PCI Urology** **202 10th St. SE Suite 100** **Cedar Rapids, IA 52403**
TYPE OF INFORMATION BEING REQUESTED **Please note:** There may be a charge associated with copies of the Medical Record	For date(s) of service: ______________ ☐ Discharge Summary ☐ History & Physical Report ☐ Emergency Room Report ☐ Laboratory/ Pathology Report ☐ Imaging Report ☐ Film ☐ Operative Report ☐ Office Visit Note ☐ Physical Therapy Report ☐ Abstract "Summary" Data ☐ Other (Specify) ______________ ****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY STATE OR FEDERAL LAW**** **Initial any category to BE released:** _____ AIDS / HIV- Related Information _____ Mental Health Services _____ Substance Use Treatment * _____ Genetic Screening
PURPOSE FOR DISCLOSURE	☐ Patient Care ☐ Personal Use ☐ Insurance Claim/ Coverage ☐ Legal Review ☐ Other ______________
TIME LIMIT *Notice to Recipients: Information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2 prohibits unauthorized disclosure of these records.)	I understand that I may cancel this authorization at any time by sending a written notice to the disclosing facility 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 this authorization 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. ______________ Patient or Legal Representative ______________ Date ______________ Relationship, if not patient

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

13630 02/24 AUTH REL PHI **DOC TYPE: AUTHORIZATION FOR RELEASE OF PHI**	Patient Label Here or Print: Name: ______________ DOB: ______________ MRN #: ______________