



Printed:03/09/17



LROI



OFFICE USE ONLY

Acct/MRN

Initials

Pages

Date

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Complete all sections entirely. If this authorization is not complete, it may be returned and result in delay in processing. Photo ID required at the time of request and pick up.



Patient name:	Date of Birth:	Last 4 digits of SS#:	Telephone #:
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Mercy Health Hospital or Physician office health information requested from: (Check all that apply)

- Anderson Clermont Fairfield The Jewish Hospital Westside (Mt. Airy and Western Hills)
 Springfield Regional Medical Center Mercy Memorial Hospital
 Physician/Practice Name: _____ Other Healthcare Provider: _____



Dates of service to release: (from): _____ (to): _____



Specific reports to be disclosed: (Check all that apply)

- Abstract of record (Discharge Summary, H&P, Operative Report, Consults, Test results....) Office Visit
 Emergency Department record History & Physical Operative report Discharge Summary
 Immunization record Test results (Lab, Pathology, Radiology, and Cardiac)
 Other (Images, Photos): _____
 Entire record (standard two years of information, unless otherwise specified): _____



If pick up or mailing records, format selected: Paper Electronic (CD)



I authorize disclosure of the above listed information to the following individual or organization:

Name: _____



Information to be disclosed via: (Check one)

- Mail to Address: _____
Street City State Zip Code
 Fax to number: _____ (page limitation may apply)
 Pick up location/site: _____



Purpose for disclosure: _____
(Continuation of care, Insurance, Legal, Please specify) – For Personal use if not otherwise stated

- I understand and acknowledge that the requested health information to disclose may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS related conditions, and/or alcohol/drug abuse. This authorization does not include disclosure of Psychotherapy notes (not included in the Mercy Health Legal health record – separate authorization, only provider/author of notes can disclose)
- This authorization will expire one year from the date of signature below unless otherwise specified.
- I understand and acknowledge that I have the right to cancel/revoke this authorization in writing to the Health Information Manager or other designated representative at the site the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to Treatment, Operations or Payment disclosures to insurance companies when the law gives the right to the insurers to contest a claim under policy
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed as provided by the federal government's rules, which are stated in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Privacy Officer for the site I have requested information from
- **If this authorization is not complete, it may be returned and may result in information not being released until properly completed**
- There may be a charge for copies of records



Signature of Patient/Patient's Legal Representative _____ Date _____

Relationship to patient: _____ (Supporting documentation of authority must be provided)

Witness (optional): _____