MERCYHEALTH

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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 #:**

Mercy Health Hospital or Physician office health information requested from: (Check all that apply)

☐ Mercy Regional Medical Center ☐ Mercy Allen Hospital ☐ Cancer Center ☐ HealthSpan

☐ 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):_____