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AUTHORIZATION FOR RELEASE OF PROTECTED 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**.

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Signature of Patient/Patient's Legal Representative Date	Patient name:	Date of Birth:	Last 4 digits of SS#:	Telephone #:			
Street City State Zip Code Mercy Health Hospital or Physician office health information requested from: (Check all that apply) Allen Hospital Lorain Hospital HealthSpan	Patient Address:		<u> </u>	<u>I</u>			
Allen Hospital Lorain Hospital HealthSpan		Cit	y State	Zip Code			
Physician/Practice Name:	Mercy Health Hospital or Physician office health information requested from: (Check all that apply)						
Specific reports to be disclosed: (Check all that apply)	Allen Hospital Lorain Hospital HealthSpan						
Specific reports to be disclosed: (Check all that apply) Abstract of record (Discharge Summary, H&P, Operative Records, Consults, Test Results) Office Visit Emergency Department record History & Physical Operative record Discharge Summary Immunization record Test results (Lab, Pathology, Radiology, and Cardiac) Itemized Bills Therapy Notes Other (Images, Photos): Entire record (standard two years of information, unless otherwise specified): I authorize disclosure of the above listed information to the following individual or organization: Self OR Name: My lock up or mailing records, requested format: Paper or Electronic (PDF/CD) PDF/CD default if not specified 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: My Chart On-site review — by appointment, Minimum 48 hour notice required Secure email: (lacknowledge the risks associated with information sent via email that is not secure and Mercy Health is not liable for disclosures misdirected or intercepted in transmission). Purpose for disclosure: (Continuation of care, Insurance, Legal, Please specify) — For Personal use if not otherwise stated Understand and acknowledge that the requested health information to disclose may contain information regarding physical and mental lilness, HIV test results or diagnosis, treatment of AIDS/AIDS related conditions, exauly transmitted diseases and/or alcohol/drug abuse. This authorization does not included in the Mercy Health Legal Health Record — separate authorization, only provider/author cnotes can disclose)	Physician/Practice Name: Other Healthcare Provider:						
Abstract of record (Discharge Summary, H&P, Operative Records, Consults, Test Results) Office Visit	Dates of service to release: (from):	(to):					
Emergency Department record	Specific reports to be disclosed: (Check all that apply)						
Immunization record	Abstract of record (Discharge Summary, H&P, Operation	e Records, Consults, Tes	st Results)	Office Visit			
Therapy Notes Other (Images, Photos): Entire record (standard two years of information, unless otherwise specified): I authorize disclosure of the above listed information to the following individual or organization: Self OR Name: If pick up or mailing records, requested format: Paper or Electronic (PDF/CD) PDF/CD default if not specified Information to be disclosed via: (Check one) Mail to Address: Street City State Zip Code Fax to number: On-site review — by appointment, Minimum 48 hour notice required Secure email: In one-site review — by appointment, Minimum 48 hour notice required Secure email: I clacknowledge the risks associated with information sent via email that is not secure and Mercy Health is not liable for disclosures misdirected or intercepted in transmission). Purpose for disclosure: (Continuation of care, Insurance, Legal, Please specify) — For Personal use if not otherwise stated 1 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, sexually transmitted diseases and/or alcohol/drug abuse. This authorization notes can disclose) 1 Insulationation will expire one year from date for Ohio & Kentucky and 60 days from date for Michigan. 1 Understand and acknowledge that I have the right to revoke this authorization at any time. I understand I must do so in writing via mail or faxing to the location the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to information that has already been disclosed. This does not apply to information that has already been disclosed. This does not apply to information to require as separation. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information to be used or disclosed as provided by the federal government's rules, which are stated in the United State	☐ Emergency Department record ☐ History & P	hysical Oper	ative record	Discharge Summary			
Therapy Notes Other (Images, Photos): Entire record (standard two years of information, unless otherwise specified): I authorize disclosure of the above listed information to the following individual or organization: Self OR Name: If pick up or mailing records, requested format: Paper or Electronic (PDF/CD) PDF/CD default if not specified Information to be disclosed via: (Check one) Mail to Address: Street City State Zip Code Fax to number: On-site review — by appointment, Minimum 48 hour notice required Secure email: In one-site review — by appointment, Minimum 48 hour notice required Secure email: I clacknowledge the risks associated with information sent via email that is not secure and Mercy Health is not liable for disclosures misdirected or intercepted in transmission). Purpose for disclosure: (Continuation of care, Insurance, Legal, Please specify) — For Personal use if not otherwise stated 1 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, sexually transmitted diseases and/or alcohol/drug abuse. This authorization notes can disclose) 1 Insulationation will expire one year from date for Ohio & Kentucky and 60 days from date for Michigan. 1 Understand and acknowledge that I have the right to revoke this authorization at any time. I understand I must do so in writing via mail or faxing to the location the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to information that has already been disclosed. This does not apply to information that has already been disclosed. This does not apply to information to require as separation. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information to be used or disclosed as provided by the federal government's rules, which are stated in the United State	☐ Immunization record ☐ Test results	(Lab, Pathology, Radiolo	ogy, and Cardiac)	Itemized Bills			
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If pick up or mailing records, requested format: Paper or Electronic (PDF/CD) PDF/CD default if not specified 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: (I acknowledge limitation may apply) Pick up location/site: (I acknowledge the risks associated with information sent via email that is not secure and Mercy Health is not liable for disclosures misdirected or intercepted in transmission). Purpose for disclosure: (Continuation of care, Insurance, Legal, Please specify) – For Personal use if not otherwise stated U 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, sexually transmitted diseases 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 or notes can disclose) 1 This authorization will expire one year from date for Ohio & Kentucky and 60 days from date for Michigan. 1 Understand and acknowledge that I have the right to revoke this authorization at any time. I understand I must do so in writing via mail or faxing to the location 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 authorization will be disclosure of this health information is voluntary. I can refuse to sight this administration is not need to sigh this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information to be used or disclosed as provided by the federal government's rules, which are stated in the unauthorized re-disclosure and th		<u> </u>	-				
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