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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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Date				

Patient name:	Date of Birth:	Last 4 digits of SS#:	Telephone #:	
Patient Address:Street				
	City		Zip Code	
Mercy Health Hospital or Physician office health inf	·			
St. Elizabeth Boardman Hospital St. Elizabeth	Youngstown Hospital	St. Joseph Warren Hosp	oital	
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, Opera Emergency Department record History & Immunization record Test result Therapy Notes Other (Images, Photos):  Entire record (standard two years of information, unit	ative Records, Consults, Tes & Physical Opera ults (Lab, Pathology, Radiolo	ative record ogy, and Cardiac)		
I authorize disclosure of the above listed information to  Self OR Name:	· ·	•		
If pick up or mailing records, requested format:	Paper or Electronic (PI	OF/CD) PDF/CD defau	It if not specified	
Information to be disclosed via: (Check one)  Mail to Address:  Street  Fax to number:		sity State age limitation may apply)	•	
Pick up location/site:				
	site review — by appointmen			
Secure email: is not secure and Mercy Health is not	·			
Purpose for disclosure:				
(Continuation of care, Insurance, Legal, Please specify)	) – For Personal use if not o	therwise stated		
<ul> <li>I understand and acknowledge that the requested health int test results or diagnosis, treatment of AIDS/AIDS related conot include disclosure of Psychotherapy notes (not include notes can disclose)</li> <li>This authorization will expire one year from date for Ohio &amp; I understand and acknowledge that I have the right to revok the location the authorization was submitted to. This does not operations or Payment disclosures to insurance companies.</li> <li>I understand that authorizing the disclosure of this health inform to obtain treatment unless the sole purpose for the tree participation requires a separate authorization by the patient provided by the federal government's rules, which are state that any disclosure of information carries with it the potential confidentiality rules. If I have questions about disclosures of was submitted to.</li> <li>I understand if I am requesting my information while I am In I will need to request after services are completed and finalising signature date.</li> <li>There may be a charge for copies of records.</li> </ul>	Inditions, sexually transmitted of in the Mercy Health Legal Health Le	diseases and/or alcohol/dr. alth Record – separate aut ate for Michigan. e. I understand I must do so s already been disclosed. To the insurers to contest a fuse to sign this authorization rmation for which this author ect or copy the information Federal Regulations at set sure and the information m contact the Release of Infor on-going services, my reco	ng abuse. This authorization de horization, only provider/authorization, only provider/authorization, only provider/authorization, only provider/authorization and apply to Treatme claim under policy on. I do not need to sign this prization is necessary. Resear to be used or disclosed as cition 164.524. I understand any not be protected by federal mation department the requested may not be complete and	
Signature of Patient/Patient's Legal Representative				