Mercy Health

Authorization for Use and Disclosure of Protected Health Information

Patient's Identification:

Patient's Name:_____ Date of Birth: _____

Other Name(s) Used: _____

Address: _____

City: _____ State: _____ Zip: _____

Last 4 Digits of Social Security #:_____ Phone Number: _____

Who is Authorized to Release PHI ("Provider"):

Name:_____

Address:_____

City: _____ State: _____ Zip: _____

Who is Authorized to Receive PHI:

Name:_____

Address:_____

City: _____ State: _____ Zip: _____

I request that PHI be provided in the following format *(if readily reproducible in this format):*

☐ Paper Copy ☐ Secure E-Mail ☐ CD ☐ Fax

Purpose of Request *(must check one):*

☐ At the Request of the Patient ☐ Attorney/Legal ☐ Billing/Payment ☐ Treatment or Consultation

☐ Other, (specify):_____

Description of PHI to be Released *(check all that apply):*

☐ Complete Medical Records
☐ History/Physical Exams
☐ Lab Test Result(s)
☐ Emergency Record(s)
☐ Discharge Summary
☐ Abstract
☐ Consultation(s)
☐ Diagnostic Testing Reports(s)
☐ EKG/Cardiology/Report(s)
☐ Itemized Billing Statement(s)
☐ Nurses Notes
☐ Psychotherapy/ SUD Counseling Notes
☐ Operative Report(s)
☐ Patient Allergies
☐ Pathology Report(s)
☐ Patient Medication(s)
☐ Clinic Records
☐ Physician Order(s)
☐ Progress Note(s)
☐ Radiology Reports/Images
☐ Treatment Plan(s)
☐ Therapy Records
☐ Other *(specify):* _____

NOTE: ***If Psychotherapy/Substance Use Disorder Counseling Notes is selected above, <u>NO OTHER BOX MAY BE SELECTED</u>. Federal law requires an independent authorization for such notes.***

If the PHI identified above includes any information about substance use disorder, mental health, genetic information, sexually transmitted diseases, HIV/AIDS testing or treatment or any other sensitive information, by signing this Authorization, I confirm that I authorize its release unless I otherwise specify in detail what is to be excluded below. I understand I have the right to request access to or a copy of my PHI so that I can review and specifically identify any information I would not like disclosed:

_____

Dates of Service for PHI to be Released *(must check one):*

☐ Any and all* ☐ From *(date)*: _____ To *(date)*: _____

**** Indicating "any and all" records to be released will include all records through the date the patient or patient representative signs this Authorization as long as the Authorization is not expired or revoked.***

Form continues on back side.

Right to Revoke: I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to Provider's address listed above, Attention - Health Information Management Department, and that the revocation will be effective upon receipt of this notice by Provider except to the extent that action has already been taken in reliance on this Authorization, or, if this authorization was given as a condition of obtaining insurance coverage, where other law provides that the insurance company has the right to contest a claim under the insurance policy.

Expiration Date or Event: This Authorization will expire 12 months from the date of my signature below unless I revoke this Authorization or unless I otherwise specified here: _____

Re-Disclosure: I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements. Mercy cannot be held liable for such redisclosures.

Charges for Release: Mercy may charge any designated recipient fees as permitted by applicable law for the release of records under this Authorization. Depending on your relationship with the requestor, they may pass those charges onto you. We are not required to provide records to a recipient under this Authorization until such fees have been paid. All request(s) for health information are processed in the order received and within the time frames required by law. Upon Mercy's receipt and review of a request, we may contact you to clarify the scope of your authorized release or to discuss the requested release of such records and any related fees. If you would like an estimate of the related fees to process a request, please contact us.

Signing This Authorization is Voluntary: I understand that I do not have to sign this Authorization and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing the Authorization.

Signature of Patient or Personal Representative: By signing this Authorization, I authorize disclosure of protected health information of above named patient by Provider as described above in this Authorization.

_____ _____ _____

Signature of Patient or Personal Representative *Date* *Time*

If this Authorization is signed by the patient's personal representative: Please specify below the personal representative's printed name, indicate personal representative's authority to act on behalf of the patient and attach supporting documentation:

_____

Personal Representative's Printed Name/Authority to Act on Behalf of Above Named Patient

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OFFICE USE ONLY

Verified by:_____

Identity of Requestor Verified via:

☐ Photo ID ☐ Matching Signature ☐ Other, specify: _____

Documentation supporting personal representative's authority to act on behalf of the patient is attached:

☐ Yes ☐ No ☐ Not Applicable

Document Type Validated: _____