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: Mercy Clinic Orthopedics

Address: 621 S. New Ballas Rd. | Suite 63B

City: St. Louis State: MO Zip: 63141

Who is Authorized to Receive PHI: **Your Employer/Disability Handler:** ☐ Employer ☐ AFLAC ☐ Insurance

Name:______________________

Address:______________________

City: ______________ State: ________ Zip: ________

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

☐ Paper Copy ☐ Secure Email ☐ CD

Purpose of Request *(must check one):*

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

☑ Other, (specify): FMLA/Disability Use Only

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

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

NOTE: *This form MAY NOT BE used to release Psychotherapy Notes*

If the PHI release of which is authorized contains information about drug/alcohol abuse, mental health treatment, 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 state here:

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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.

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.

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:

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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: ______________________________