



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification	
Printed Name:	Date of Birth:
Address:	SSN:
	Telephone:

Information is to be released by:	Information is to be sent to:
Mercy Clinic Cancer Care 607 S. New Ballas, Suite 3300 St. Louis, MO 63141 phone 314-251-4400 fax 314-251-6375	_____
	(Individual/ Agency/ Facility)

	(Street Address)

	(City, State, and Zip Code)

	(Telephone Number)

Information To Be Released - Covering the Periods of Health Care	
From (date)	To (date)

Please check type of information to be released:		
<input type="checkbox"/> Complete health record	<input type="checkbox"/> Diagnosis & treatment codes	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> Complete billing record	<input type="checkbox"/> X-ray films / images
<input type="checkbox"/> Other (specify)		

Purpose of Request		
<input type="checkbox"/> Treatment or consultation	<input type="checkbox"/> At the request of the patient	<input type="checkbox"/> Billing or claims payment
<input type="checkbox"/> Other (specify)		

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check One: <input type="checkbox"/> Yes <input type="checkbox"/> No
I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. Check One: <input type="checkbox"/> Yes <input type="checkbox"/> No

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of HIS or other Department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event _____, or 90 days from date of signature, unless otherwise specified.

Re-release
I understand the information released pursuant to this Authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure	
Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. By signing below, you authorize your provider, identified above, to release your protected health information specified above.	
Signature:	Date:
Authority to Sign - if not patient:	Witness:
Identity of Requestor Verified via: <input type="checkbox"/> Photo ID <input type="checkbox"/> Matching Signature <input type="checkbox"/> Other, specify:	
ID Verified by:	