Mercy

Request for Release Restriction

Request for Non-Disclosure of Medical Information to Insurance

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Medical Record Number: _____

Insurance Carrier: _____

Date of Service/Encounter/Episode: _____

Confidential Service Provided: _____

Provider Name (if known): _____

Facility Location: _____

By signing below, I hereby request that Mercy not release medical or billing information about the service(s) I will personally pay for, which are listed above (the Confidential Service), to my insurance carrier. I understand and agree that if Mercy receives from my insurance carrier a release signed by me or my personal representative that authorizes release of my medical records to the insurance company, this restriction will end and be no longer in effect. If payment for services is declined, and I do not provide another form of payment when contacted by Mercy, the insurance carrier will be billed for charges and this restriction will not be in effect. I also understand that if I obtain future services that my insurance carrier pays for and information about the Confidential Service is important for my safe and effective care, documentation about the Confidential Service may be in records of future services that my insurance company pays for and will have a right to review.

_____ _____ _____

Signature of Patient or Legal Personal Representative | Date | Time

_____

Authority to Sign if not the Patient

_____ _____ _____

Co-worker Accepting Restriction *(Please Print)* | Date | Time