



## Request for Release Restriction

### Do Not Disclose Medical Information to Insurance Carrier

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Date of Service/Encounter/Episode: \_\_\_\_\_

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representative that authorizes release of my medical records to the insurance company, this restriction will end and be no longer in effect.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

\_\_\_\_\_  
Authority to Sign if not the Patient

Method of Payment for Services:

Cash

Credit Card

Check

\_\_\_\_\_  
Co-worker Accepting Restriction (Please Print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date