Authorization for Release of Protected Health Information
(includes ability to discuss PHI)

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____ SSN: _____

_____ Telephone: _____

Information is to be released by:

_____
(Physician or Facility)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(Telephone Number)

Information is to be sent to:

Mercy Clinic Children's Urology
621 South New Ballas Rd Ste 537A
St. Louis MO 63141
(p) 314-251-6990 (f) 314-251-6998

Information To Be Released – Covering the Periods of Health Care
From (date) **ALL DATES** to (date) **ALL DATES**

Please check type of Information to be released:

☐ Complete health record	☐ Diagnosis & treatment codes	☐ Discharge summary
☐ Laboratory test results	☐ Complete billing record	☐ X-ray films / images
x Other (specify) **My health care provider may discuss any and all health information with the person or entity listed above.**		

Purpose of Request

☐ Treatment or consultation	x At the request of the patient	☐ Billing or claims payment
☐ 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:*** ☐ **Yes** ☐ **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:*** ☐ **Yes** ☐ **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: **end of my treatment relationship**, 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: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

ID Verified by: _____