Authorization for Release of Protected Health Information

Patient Identification
Printed Name: _____ Date of Birth_____

Address: _____ SSN: _____

_____ Telephone: _____

Information to be released by:

Physician or Facility _____

Street Address _____

City, State & Zip _____

Telephone No. _____

Fax _____

Information is to be sent to:

Mercy OB/GYN Des Peres
Suite 100
1000 Des Peres Road
St. Louis, MO 63131
Office (314)729-4440
Fax (314)729-4441

Information To Be Released: **Complete Health Record** Date: **All Dates**

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 Mercy Medical Group practice 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 my be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act if 1996. The practice, 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: _____