Mercy Health

# Authorization for Use and Disclosure of Protected Health Information

**Release TO:**

Name: Mercy Clinic Family Medicine - Kirkwood [ ] Dr. Edward C. Chen MD & [ ] Dr. Kevin P. King MD

Address: 816 South Kirkwood Road, Suite 210

City: Kirkwood State: MO Zip: 63122

Phone #: 314-822-6830 FAX: 314-822-6859

**Release FROM:**

Provider/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

**Patient or Individual Identification:**

Printed Name: _____ Date of Birth: _____

Other Name(s) Used: _____

Address: _____

City: _____ State: _____ Zip: _____

Last 4 Digits of Social Security #: _____ Phone #: _____

**Purpose of Request** *(Must check one):*

☐ Request of the Patient or Individual ☐ Attorney/Legal ☐ Billing/Payment ☒ Treatment or Consultation

☐ Other, *(specify)*: _____

**I Request My Records be Provided:** ☐ Paper *(hard copy)* ☐ Electronically via email* ☐ Electronically via CD*

Email address: PLEASE FAX OR MAIL RECORDS TO MERCY CLINIC FAMILY MEDICINE - KIRKWOOD

** Electronic availability is subject to location and type of records. Billing records & films cannot be provided electronically and are available for mail or pick-up only.*

**Information to be Released – Covering the Periods of Health Care** *(must check one):*

☐ Any and all** ☐ From (date): _____ To *(date)*: _____

*** includes all records through the date the patient or patient representative signs this authorization.*

**Please check type of information to be released** *(check all that apply):*

| | | | |
|---|---|---|---|
| ☐ Complete Medical Record | ☐ Consultation(s) | ☐ Operative Report(s) | ☐ Physician Order(s) |
| ☐ History / Physical Exams | ☐ Diagnostic Testing Report(s) | ☐ Patient Allergies | ☐ Progress Note(s |
| ☐ Lab Test Result(s) | ☐ EKG/Cardiology/Report(s) | ☐ Pathology Report(s) | ☐ Radiology Reports/Image(s) |
| ☐ Emergency Record(s) | ☐ Itemized Billing Statement(s) | ☐ Patient Medication(s) | ☐ Treatment Plan(s) |
| ☐ Discharge Summary | ☐ Nurses Notes | ☐ Clinic Records | ☐ Therapy Records |

☐ Other (specify): _____

**NOTE:** *This form MAY NOT BE used to release Psychotherapy Notes*

**Drug and/or Alcohol Abuse, and/or Psychiatric, and Communicable/Non-Communicable Diseases**

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse or treatment, psychiatric care, communicable and/or non communicable diseases including but not limited to hepatitis, gonorrhea, syphilis and/or other sensitive information, I agree to its release. ***Check One:*** ☐ **YES** ☐ **NO**

*Form continues on back side.*

**HIV/AIDS Records Release**
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 I can revoke this authorization at any time. Unless revoked, this authorization will expire on the following date or event _____ or not to exceed 1 year from date of signature. Indicating "any and all" records to be released will only include all records through the date the patient or patient representative signs this authorization as long as the authorization is not expired or revoked.

**Re-disclosure**
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 or state statute.

**Right to Refuse**
I understand that I do not have to sign this Authorization, and my treatment or payment for services will not be denied if do not sign.

**Signature of Patient or Personal Representative Who May Request Disclosure**
**I understand there may be a charge for copying my records. State law governs what the Releasing Entity may charge.**
I have read this form, understand and agree to the uses and disclosures of information as described in this Authorization. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by State statute and/or 45 CFR §164.502(a)(1). I hereby knowingly and voluntarily authorize Mercy Health to use and disclose the protected health information specified above.

_____ _____ _____
*Signature of individual or personal representative* *Date* *Time*

Printed name of individual's personal representative, if applicable: _____

Rationale for serving as personal representative to the individual *(e.g., parent, legal guardian)*:

_____

_____

_____

Witness Signature (where legally required): _____

---

Verified by *(OFFICE USE ONLY):* _____

Identity of Requestor Verified *(OFFICE USE ONLY)* via:
☐ Photo ID ☐ Matching Signature ☐ Other, specify: _____