Mercy Clinic Women's Health
1203 Smizer Mill Rd. | Suite 106 | Fenton, MO 63026
4280 Mid America Lane | St. Louis, MO 63129
phone 636-717-1390 | fax 636-717-1395

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:

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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_____

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Authorization for Release of Protected Health Information

In our office we will do everything possible to maintain your privacy, however if you wish us to share your medical information please fill out this form. Also, please specify how we can contact you.

I, _____, give permission for you to discuss my medical condition, results and care with the following person(s) specified below.

Names(s) and relationship:

_____

_____

_____

Please mark all that apply:

_____ I do not want my medical condition discussed with anyone other than myself.

_____ I give permission for you to leave a message on my answering machine at home.

_____ I give permission for you to leave a message on my cell phone voicemail.

_____ I give permission for you to leave a message on my answering machine at work.

Signature:_____ Date:_____

Print Name: _____