MERCY SPECIALTY CLINICS, CARDIOLOGY
IOWA CITY, IOWA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Mercy Cardiology Clinic
Mercy Medical Plaza
540 E. Jefferson St., Suite 400
Iowa City, Iowa 52245
Phone: 319-339-3400
Fax: 319-339-3401

PATIENT IDENTIFICATION

Name: _____
Last First M.I.

Birth Date: _____ Social Security #: XXX-XX-_____ Medical Record #:_____

Address: _____
Street City State/Zip

Telephone Number: _____ _____
Home Other

FROM PROVIDER (Who is to release the information?)

Name: **Heart & Vascular Center - ATTN: ICHC @ IRL**
University of Iowa Hospitals & Clinics
Street Address: **105 E. 9th St**
City, State, Zip: **Coralville, IA 52241**
Phone # **319-339-3883**
Fax #: **319-339-3882**

TO RECIPIENT (Who is to receive the information?)

Name: **Mercy Cardiology Clinic**
Street Address **540 E Jefferson St, Suite 400**
City, State, Zip: **Iowa City, IA 52245**
Phone #: **319-339-3400**
Fax #: **319-339-3401**

TYPE OF INFORMATION BEING REQUESTED

For date(s) of service: _____ / _____ / _____ to _____ / _____ / _____

- ☐ History and Physical Report
- ☐ Medication List
- ☐ EKG
- ☒ Other
  (Specify): CCDA and entire medical record
- ☐ Clinic Notes
- ☐ Problem List
- ☐ Laboratory Report
- ☐ X-Ray Report
- ☐ Stress Tests
- ☐ CCDA

****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY STATE OR FEDERAL LAW****

Initial any category NOT to be released

_____ Acquired immunologic syndrome (AIDS) or human immunodeficiency virus (HIV)
_____ Alcohol and drug abuse treatment
_____ Behavioral or mental health services

PURPOSE FOR DISCLOSURE

- ☒ Patient Care
- ☐ Insurance Claim
- ☐ Other: (Specify): _____
- ☐ Personal Use (Fees Apply)
- ☐ Legal Review (Fees Apply)

TIME LIMIT

I understand that I may cancel (revoke) this authorization at any time by sending a written notice to Mercy Specialty Clinic, Cardiology and that my cancellation will take effect when the written notice is received and it will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one year from the date of signature except as specified. (Specify expiration date, event, or condition:_____.)

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations unless otherwise prohibited from re-disclosure under other federal and/or state laws or regulations.

SIGNATURE AND DATE

_____ _____
Signature (Patient or Legal Representative) Date

_____ _____
Relationship, if not patient Witness