



MERCY HOSPITAL, IOWA CITY, IOWA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

#9-19 (6/13 revised)

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Clinical Information Services 500 E. Market St. Iowa City Iowa 52245 Phone: 319-339-3682 Fax: 319-339-3785

PATIENT IDENTIFICATION	Name: _____ Last First M.I. Birth Date: _____ Social Security #: _____ Medical Record #: _____ Address: _____ Street City State/Zip Telephone Number: _____ Home Other
FROM PROVIDER (Who is to release the information?)	Name: _____ Street Address _____ City, State, Zip _____ Phone #: _____ Fax #: _____
TO RECIPIENT (Who is to receive the information?)	Name: _____ Street Address: _____ City, State, Zip _____ Phone #: _____ Fax #: _____
TYPE OF INFORMATION BEING REQUESTED	For date(s) of service: ____ / ____ / ____ to ____ / ____ / ____ <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Operative Report <input type="checkbox"/> X-Ray Report <input type="checkbox"/> Image <input type="checkbox"/> History & Physical Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Consults <input type="checkbox"/> Emergency Room Report <input type="checkbox"/> Laboratory Report <input type="checkbox"/> Abstract Summary <input type="checkbox"/> Other (Specify): _____ <hr/> **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	<input type="checkbox"/> Patient Care <input type="checkbox"/> Personal Use (Fees Apply) <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Legal Review (Fees Apply) <input type="checkbox"/> Other: (Specify): _____
TIME LIMIT	I understand that I may cancel (revoke) this authorization at any time by sending a written notice to Mercy's Health Information (Medical Records) department 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