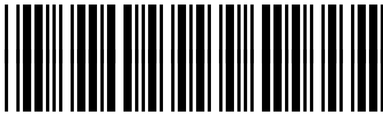

MERCY HOSPITAL, IOWA CITY, IOWA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

#9-19 (10/23/17 revised)

Clinical Information Services 500 E. Market St. Iowa City Iowa 52245 Phone: 319-339-3609 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: MERCY HOSPITAL IOWA CITY Street Address 500 E. Market St. City, State, Zip Iowa City, Iowa, 52245 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** ____ / ____ / ____ ☐ Discharge Summary ☐ Operative Report ☐ X-Ray Report ☐ Image ☐ History & Physical Report ☐ Pathology Report ☐ Consults ☐ Emergency Room Report ☐ Laboratory Report ☐ Abstract Summary ☐ Other (Specify): ________
	****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 ☐ Personal Use (Fees Apply) ☐ Insurance Claim ☐ Legal Review (Fees Apply) ☐ 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