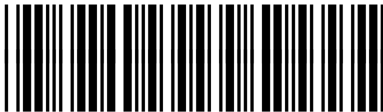

MERCY HOSPITAL, IOWA CITY, IOWA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

#9-19 (7/11 revised)

PATIENT IDENTIFICATION	Name: ____________________ Last / First / M.I. Birth Date: __________ Social Security #: __________ Medical Record #: __________ Address: ____________________ Street / City / State/Zip Telephone Number: __________ Home __________ Other
INFORMATION BEING SENT TO/FROM (CHECK ONLY ONE)	☐ This information is to be released **FROM** Mercy Iowa City to the facility or individual specified below: __________ Name of facility or individual __________ Address ______ Initial to permit for fax release for immediate or emergency patient care needs __________ Fax Number ☐ This information is to be released **TO** Mercy Iowa City __________ Department Name __________ Name of facility or individual __________ Address __________ Phone Number __________ Fax Number
TYPE OF INFORMATION BEING REQUESTED	For date(s) of service: _____ / _____ / _____ to _____ / _____ / ______ ☐ Discharge Summary ☐ History & Physical Report ☐ Emergency Room Report ☐ Laboratory Report ☐ X-Ray Report ☐ Image ☐ Operative Report ☐ Pathology Report ☐ Physical Therapy Report ☐ Abstract "Summary" Data * ☐ Other (Specify): __________ ☐ Consults ☐ Medication/Allergy Lists ****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 ☐ Second opinion ☐ Personal Use (Fees Apply) ☐ Insurance Claim ☐ Transferring care ☐ Legal Review ☐ Other:
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:____________________.)
SIGNATURE AND DATE (A copy of this signed form will be offered to the patient.) ☐ Copy made	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 (Patient or Legal Representative) __________ Date __________ Relationship, if not patient __________ Witness

MERCY USE ONLY: Information processed and sent Initials __________ Date ____ / ____ / ______ ☐ Received Fees Sheet