MERCYCARE COMMUNITY PHYSICIANS

Authorization for Release of Protected Health Information (PHI)

Patient Information

Name: _____ (Last) _____ (First) _____ (MI)

Birth Date: _____ (xx/xx/xxxx) Maiden/Other Name: _____

Telephone Number: ( ) _____

Provider releasing PHI

HealthCare Provider: _____

PHI Requested to be Released*

- ☐ Office visit notes only
- ☐ Immunization/Shot records
- ☐ Physical Therapy Report
- ☐ X-ray Report/Films of _____
- ☐ Lab Results
- ☐ All records
- ☐ Pre-employment physical exam
- ☐ Worker's Compensation records
- ☐ Electrocardiogram (EKG) Report
- ☐ Pregnancy Records
- ☐ Other: _____ (Please specify)

Specify Dates of Service (if applicable): _____

*** Required Authorization**

Specific Authorization for Release of Information which is Further Protected under State and/or Federal Law.

- Y / N Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
- Y / N Alcohol or drug abuse treatment
- Y / N Behavioral or mental health services

Party(s) to receive Patient's PHI as indicated below

Name: _____ Organization: _____

- ☐ Mail to address: _____
- ☐ By Phone ( ) _____ By Fax: ( ) _____

Name: _____ Organization: _____

- ☐ Mail to address: _____
- ☐ By Phone ( ) _____ By Fax: ( ) _____

Purpose for Disclosure

- ☐ New Healthcare provider
- ☐ Legal purpose
- ☐ Personal Use
- ☐ Insurance
- ☐ Other: _____ (Please specify)

Authorization Expiration

I understand that I may cancel (revoke) this authorization at any time by sending a written notice to MercyCare Community Physicians and that my cancellation will take effect when the written notice is received. I understand it will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one (1) year from date of signature except as specified below:

Expiration Date, Event or Condition limitation: _____

Signature and Date

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 released. I understand that if the person or entity that receives the information is not a healthcare 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.

_____ (Patient Signature or Responsible Party) _____ (Date)

_____ (If Responsible Party, state relationship or basis for authority to sign.)

☐ *Copy to Patient or Responsible Party* ☐ *Verified ID, provided release, logged (staff initials):*

Rev: 03/2012