701 10th St
Cedar Rapids, IA 52403
(319) 398–6160

**Mercy Medical Center**

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

### PATIENT IDENTIFICATION

Name: ______________________________
Last First M.I.

Birth Date: ____________ Social Security #: ____________
Optional – Last 4 digits only

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 Medical Center to the facility or individual speci–fied below:

______________________________
Name or 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 Medical Center:

**Mercy Gastroenterology Clinic**
**788 8th Ave. SE, Suite 300**
**Cedar Rapids, IA 52401 Fax: (319) 369-4543**

from the facility or individual specified below:

**UnityPoint Health - St. Luke's Gastroenterology**
**931 8th Ave. SE**
**Cedar Rapids, IA 52401**

### TYPE OF INFORMATION BEING REQUESTED

**Please note:** There may be a charge associated with copies of the Medical Record

For date(s) of service: ______________________________

☐ Discharge Summary ☐ History & Physical Report ☐ Emergency Room Report
☐ Laboratory Report ☐ X–ray Report ☐ Film ☐ Operative Report
☐ Pathology Report ☐ Physical Therapy Report ☐ Abstract "Summary" Data

☒ Other (Specify) **ALL RECORDS**

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

**I specifically authorize the release of the following information (initial any category 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 **TRANSFER OF CARE / MEDICAL RECORDS**
☐ Personal Use
☐ Legal Review

### TIME LIMIT

I understand that I may cancel 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 six (6) months 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 redisclosed and no longer protected by federal privacy regulations unless otherwise prohibited from redisclosure under other federal and/or state laws or regulations.

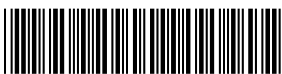
### SIGNATURE AND DATE
(A copy of this signed form will be provided to the patient.)

______________________________ ____________
Signature (Patient or Legal Representative) Date

______________________________
Relationship, if not the patient

Photo ID Checked ☐ Information processed and sent (date and initials) ______________________________

999–50022 04/16 070262



AUTH REL

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Original – Medical Record
Copy – Patient

Patient Account #: ______________________________

Patient Unit #: ______________________________