MERCY CEDAR RAPIDS

Mercy Medical Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Mercycare Service Corporation
701 10th Street SE, Cedar Rapids, IA 52403
Phone: (319) 398-6845; Fax: (319) 398-6848; Email: ROI@mercycare.org

PATIENT IDENTIFICATION

List previous names (maiden, married, legal changes)

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

Previous Names (maiden, married, etc.): _____

Birth Date: _____ Social Security # _____
(Optional - Last 4 digits only)

Address: _____ _____
(Street) (City / State / Zip Code)

Phone #'s: _____ Alternate #: _____

Email (optional): _____

INFORMATION BEING SENT TO/FROM
(CHECK ONLY ONE)

Requested Format:
- ☐ Mail
- ☐ Fax: _____
- ☐ MyChart
- ☐ CD / USB (circle one)
- ☐ Email (email is not a secure means of communication

Need by: _____

☐ This information is to be released **FROM** Mercy Medical Center to the facility or individual specified below:

_____
Name and/or facility

_____
Address

_____
City / State / Zip Code

- ☐ Myself (at the Address Listed Above)
- ☐ Pickup
- ☐ Call When Ready

☐ This information is to be released **TO** Mercy Medical Center

_____
Facility / Department Name

from the facility or individual specified below:

_____
Name and/or facility

_____
Address

_____
City / State / Zip Code

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/ Pathology Report
- ☐ Imaging Report ☐ Film
- ☐ Operative Report
- ☐ Office Visit Note
- ☐ Physical Therapy Report
- ☐ Abstract "Summary" Data
- ☐ Other (Specify) _____

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

Initial any category to BE released:

_____ AIDS / HIV- Related Information
_____ Substance Use Treatment *
_____ Mental Health Services
_____ Genetic Screening

PURPOSE FOR DISCLOSURE

- ☐ Patient Care
- ☐ Insurance Claim/ Coverage
- ☐ Other _____
- ☐ Personal Use
- ☐ Legal Review

TIME LIMIT

*Notice to Recipients: Information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2 prohibits unauthorized disclosure of these records.)

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 this authorization 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.

_____ _____
Patient or Legal Representative Date

_____
Relationship, if not patient

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

13630 02/24

AUTH REL PHI

DOC TYPE: AUTHORIZATION FOR RELEASE OF PHI

Patient Label Here or Print:

Name: _____

DOB: _____ MRN #: _____