Mercy

Mercy Health Springfield Communities
Authorization for Use and Disclosure of Protected Health Information

Release TO: Name: Rose Nelson - Medical Destinations
Address: 1229 East Seminole Suite 320
City, State & Zip: Springfield, MO 65804
Phone #: 417-820-9795 Fax #: 417-820-8873

Release FROM: Facility: _____
Address: _____
City, State & Zip: _____

Patient Identification:
Printed Name: _____ Date of Birth: _____
Address: _____
City & State: _____ ZIP: _____
Social Security #: _____ Phone #: _____

Information to be Released – Covering the Periods of Health Care *(Please fill in date(s))*:
From (date): _____ To (date): _____

Please check type of information to be released:

____ History & Physical	____ Lab test result(s)	____ Diagnosis & Treatment Code(s)	____ Operative Report(s)
____ Consultation Report(s)	____ X-Ray Report(s)	____ Progress Note(s)	____ ER Report(s)
____ Discharge Summary	____ X-Ray Film/Image(s)	____ Photograph(s), Videotape(s)	____ Medication(s)
____ Complete Billing Record	____ Itemized Bill	____ Pathology Report(s)	____ Treatment(s)

Other, (specify): _____

Purpose of Request *(Must check one):*
____ Treatment or Consultation ____ At the request of the patient ____ Billing or claims payment
Other, (specify): _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One: ___ YES ____ NO**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check One: ___ YES ____ NO**

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Privacy Site Coordinator or to the Privacy Officer. Please refer to the Notice of Privacy Practices for appropriate mailing address. Unless revoked, this authorization will expire on the following date or event _____ , or not to exceed 1 year from date of signature.

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-discloser by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under **Purpose of Request**. I can inspect or copy the protected health information to be used or disclosed**. I authorize Mercy to use and disclose the protected health information specified above.**

Signature: _____ **Date:** _____

Authority to Sign if not the patient: _____
Verified by *(OFFICE USE ONLY):* _____
Identity of Requestor Verified *(OFFICE USE ONLY)* via: ___ Photo ID ___ Matching Signature ___ Other, specify: _____