

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____ Date of Birth: _____

Other Names Used: _____ Telephone Number: _____

Medical Record or Account#: _____

(Hospital use only)

I AUTHORIZE: _____ Mercy Hospitals _____

(Facility or other provider)

TO DISCLOSE TO: _____

(Persons/organizations authorized to *receive* the information)

at the following address: _____

(street, city, state and zip code)

the following information contained in the records specified below (check box and initial applicable lines below):

____ Mental health or developmental disability treatment records (excludes
“psychotherapy notes”)

____ Substance abuse treatment records

____ HIV test results (This authorizes disclosure of laboratory test results only.)

Note that your records may include information concerning your HIV status even if you do not initial this line.

THE FOLLOWING RECORDS, specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

Billing Records Emergency Room Procedure Reports

Consultation Reports Progress Notes

Reports History and X-ray Reports

Discharge Physical

Summary Laboratory Tests

Date(s): _____

Other: _____

ALL RECORDS regarding my treatment, hospitalization, and outpatient care.

Note: A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

