MERCY

1ROI

Acct # _____
Initials _____
Pages _____
Date _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

MHP Facility(s) treated at: _____

Patient Name: _____ Patient Phone No._____

Medical Record Number: _____ Date of Birth: _____

1. I authorize **Mercy, other:** _____ to disclose the following protected health information about the above-named patient: (include dates where appropriate)

[ ]	problem list	[ ]	medication list
[ ]	immunization record	[ ]	most recent history and physical
[ ]	most recent discharge summary	[ ]	laboratory results
[ ]	Consultation report	[ ]	x-ray and imaging reports

[ ] Other (describe specifically what is to be disclosed): _____

[ ] entire record (excluding psychotherapy records, if any exist) for all records from;
(Date) _____ To (date) _____.

2. Health information is to be disclosed to: _____
Please mail records to:
Address:_____
City: _____ State: _____ Zip Code: _____

3. If I fail to specify, the purpose of this authorization is: Individual's request. Other: _____

4. I understand the information to be disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment **or testing** for alcohol or drug abuse.

5. I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to the authorized party (#1). I understand that a cancellation will not apply to information that has already been released under this authorization. I understand that the cancellation will not apply to my insurance company when the law gives my insurer with the right to contest a claim under my policy.

6. If I fail to specify, this authorization will expire one year from the date appearing at the bottom. This authorization will expire on the following date, event or condition: _____.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer for the Mercy facilities located in Toledo at 947 S. Wheeling Oregon, Ohio 43616.

_____ _____
Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to patient: _____
(Attach copy of paper work verifying legal authority)

Witness: _____

Photo ID is required when requesting and picking up PHI. Key patient identifier required for all verbal communications.