

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ MR# _____

Patient Address: _____

Social Security #: _____ Home Phone#: _____ Work Phone#: _____

I, _____, hereby authorize Mercy Medical Center, Craven-Hagan Clinic, Mercy Behavioral Health, Mercy Health Partners, Mercy Leonard P. Nelson Cancer Treatment Center or _____ to use and/or disclose my individually identifiable health information as described below:

I authorize the following person(s) or organization to receive the information: _____

Street Address: _____

City, State, and Zip Code: _____

The following individually identifiable health information may be used and/or disclosed:

Check (✓) all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Reports of Tests & X-rays | <input type="checkbox"/> Inpatient Records |
| <input type="checkbox"/> Face sheets with Final Diagnosis | <input type="checkbox"/> Emergency Room Records | <input type="checkbox"/> Outpatient Records |
| <input type="checkbox"/> Complications, and Procedures | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Abstracts |
| <input type="checkbox"/> History and Physical Records | <input type="checkbox"/> Immunization (shot) Record | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Outpatient Clinic Notes | <input type="checkbox"/> Last Physical Exam | <input type="checkbox"/> Pap Smear |
| <input type="checkbox"/> Pelvic Exam | <input type="checkbox"/> Breast Exam | <input type="checkbox"/> Chlamydia/Gonorrhea |
| <input type="checkbox"/> Labs | <input type="checkbox"/> Biopsy/Colposcopy Results | |
| <input type="checkbox"/> Other*: _____ | | |

* If authorization is for *marketing*, indicate if **Mercy Medical Center** will receive compensation in exchange for the use and/or disclosure of the PHI. YES or NO

Dates of treatment to be released: _____

I authorize the release of any information contained in the above records concerning treatment of:

- | | |
|--|--|
| <input type="checkbox"/> Drug or Alcohol abuse | <input type="checkbox"/> Drug-related conditions |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Psychiatric/psychological condition |
| <input type="checkbox"/> Psychiatric/mental health treatment | <input type="checkbox"/> HIV -related conditions |

Reason or purpose for the use and/or disclosure of the information:

Prohibition on Conditioning of Authorization: Mercy Medical Center will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire 60 days from signature and date on authorization form.

Revocation: I understand that I may revoke this authorization at any time by notifying Mercy Medical Center in writing by sending a letter to Health Information Management Departments or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Mercy Medical Center took before it received my revocation letter. For example, Mercy Medical Center cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Mercy Medical Center’s Notice of Privacy Practices.

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE

DATE

Printed name of individual’s personal representative, if applicable: _____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian): _____

FOR INTERNAL PURPOSES ONLY

When Mercy Medical Center is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____

Date: _____

Was a signed copy provided to the individual? YES NO