

Name:					
Address:					
City:			_ State:	Zip:	
Phone #:		Fax#:			
Release FROM:					
Name:					
City:			_State:	Zip:	
Patient or Individual Identificatio	on:				
Printed Name:			Date of Birth:		
Other Name(s) Used:					
Address:					
ity:					
Last4DigitsofSocialSecurity#:		Phone#:		······	
Request My Records be Provide Paper (hard copy) Electronica Email address:	Ily via email* Fax	-	nd films cannot	t be provided	
Information to be Released – Cor Any and all** From (date):	-				
** includes all records through the d					
Please check type of information to	be released (check all the	at apply):			
Complete Medical Record History	•	Physician Order(s)			
Physical Exams		Diagnostic Testing Report(s)			
Lab Test Result(s)	_	Operative Report(s)			
Radiology Reports/Image(s)	Itemized Bi	Itemized Billing Statement(s)			
Discharge Summary	Progress No	-			
Abstract	Treatment	Plan(s)			
Other (specify):					

NOTE: This form MAY NOT BE used to release Psychotherapy Notes

Drug and/or Alcohol Abuse, and/or Psychiatric, and Communicable/Non-Communicable Diseases

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse or treatment, psychiatric care, communicable and/or non communicable diseases including but not limited to hepatitis, gonorrhea, syphilis and/or other sensitive information, I agree to its release. *Check One:* YES NO

Form continues on back side.

Release TO:

HIV/AIDS Records Release

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 I can revoke this authorization at any time. Unless revoked, this authorization will expire on the following date or event ______ or not to exceed 1 year from date of signature. Indicating "any and all" records to be released will only include all records through the date the patient or patient representative signs this authorization as long as the authorization is not expired or revoked.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 or state statute.

Right to Refuse

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.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand there may be a charge for copying my records. State law governs what the Releasing Entity may charge. I have read this form, understand and agree to the uses and disclosures of information as described in this Authorization. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by State statute and/or 45 CFR §164.502(a)(1). I hereby knowingly and voluntarily authorize Mercy Health to use and disclose the protected health information specified above.

Signature of individual or personal representative	Date	Time
Printed name of individual's personal representative, if applical	ble:	
Rationale for serving as personal representative to the individu	al (e.g., parent, legal guard	dian):
Witness Signature (where legally required):		

Verified by (OFFICEUSEONLY): _____

 Identity of Requestor Verified (OFFICE USE ONLY) via:

 Photo ID
 Matching Signature
 Other ,specify: ______