more than health care ... life care

MOSAIC™ LIFE·CARE

myMosaicLifeCare.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ACCESS REQUEST FROM MOSAIC LIFE CARE TO ANOTHER AGENCY

MRN:_____ RRID:_____

Patient Name:_____

Date of Birth:_____/_____/_____

Address:_____

_____

City:_____ State:_____ Zip Code:_____

Phone:_____

E-mail Address: _____

I request my protected health information (PHI) be released from:

☐ Mosaic Life Care

☐ Clinic Name/Please Specify:

_____

_____

_____

I request my protected health information (PHI) to be released to:

Name: _____

Address:_____

_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

E-mail Address:_____

I authorize the following PHI to be released from my medical record(s):

☐ Pertinent Information
☐ Emergency Room Report
☐ Consultations
☐ Operative Reports
☐ Radiology Reports
☐ History & Physical
☐ Lab Results
☐ Pathology Results
☐ Pathology Slides
☐ Discharge Summary
☐ Radiology Films/Other Diagnostic Images
☐ Complete Billing Record/Itemized Bill
☐ Complete Health Record
☐ Other_____

_____

_____

Covering the period of health care from:

☐ Specific Date(s): _____ to _____

☐ All ☐ Diagnosis_____

Purpose for requesting Information:

☐ Medical ☐ Personal ☐ Insurance ☐ Legal
☐ Disability ☐ Law Enforcement ☐ FMLA
☐ Research ☐ School ☐ Military ☐ Adoption
☐ Department of Social Service
☐ Other: _____

_____

_____

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- PHI may include records relating to mental health care, sexually transmitted diseases, Genetic/Metabolic Testing, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this authorization, and that I can inspect or copy the protected health information to be used or disclosed.
- I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. Heartland Regional Medical Center, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

Patient/Authorized Representative Signature: _____ Date: _____

Printed name of Patient/Authorized representative: _____ Relationship to patient: _____

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Identification type_____ Verified by_____ Date: _____

If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form