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Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Complete all sections entirely. If this authorization is not complete, it may be returned and result in delay in processing. **Photo ID required at the time of request.**

Patient name:	Date of Birth:	Last 4 digits of SS#:	Telephone #:
Patient Address: _____ Street _____ City _____ State _____ Zip Code _____			
Mercy Health Hospital or Physician office health information requested from: (Check all that apply) <input type="checkbox"/> St. Elizabeth Boardman Hospital <input type="checkbox"/> St. Elizabeth Youngstown Hospital <input type="checkbox"/> St. Joseph Warren Hospital			
<input type="checkbox"/> Physician/Practice Name: _____ <input type="checkbox"/> Other Healthcare Provider: _____			
Dates of service to release: (from): _____ (to): _____			
Specific reports to be disclosed: (Check all that apply) <input type="checkbox"/> Abstract of record (Discharge Summary, H&P, Operative Records, Consults, Test Results....) <input type="checkbox"/> Office Visit <input type="checkbox"/> Emergency Department record <input type="checkbox"/> History & Physical <input type="checkbox"/> Operative record <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Immunization record <input type="checkbox"/> Test results (Lab, Pathology, Radiology, and Cardiac) <input type="checkbox"/> Itemized Bills <input type="checkbox"/> Therapy Notes <input type="checkbox"/> Other (Images, Photos): _____ <input type="checkbox"/> Entire record (standard two years of information, unless otherwise specified): _____			
I authorize disclosure of the above listed information to the following individual or organization: <input type="checkbox"/> Self OR Name: _____			
If mailing records, requested format: <input type="checkbox"/> Paper or <input type="checkbox"/> Electronic (PDF/CD) PDF/CD default if not specified			
Information to be disclosed via: (Check one) <input type="checkbox"/> Mail to Address: _____ Street _____ City _____ State _____ Zip Code _____ <input type="checkbox"/> Fax to number: _____ (page limitation may apply) <input type="checkbox"/> My Chart <input type="checkbox"/> Secure email: _____ (I acknowledge the risks associated with information sent via email that is not secure and Mercy Health is not liable for disclosures misdirected or intercepted in transmission).			
<input type="checkbox"/> Purpose for disclosure: _____ (Continuation of care, Insurance, Legal, Please specify) – For Personal use if not otherwise stated			
<ul style="list-style-type: none">• I understand and acknowledge that the requested health information to disclose may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS related conditions, sexually transmitted diseases and/or alcohol/drug abuse. This authorization does not include disclosure of Psychotherapy or Substance Abuse Disorder notes (not included in the Mercy Health Legal Health Record – separate authorization, only provider/author of notes can disclose)• This authorization will expire one year from date for Ohio & Kentucky and 60 days from date for Michigan.• I understand and acknowledge that I have the right to revoke this authorization at any time. I understand I must do so in writing via mail or faxing to the location the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to Treatment, Operations or Payment disclosures to insurance companies when the law gives the right to the insurers to contest a claim under policy• 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. Research participation requires a separate authorization by the patient. 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 stated 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 disclosures of my health information, I can contact the Release of Information department the request was submitted to.• I understand if I am requesting my information while I am In House/Admitted or receiving on-going services, my record may not be complete and I will need to request after services are completed and finalized.• There may be a charge for copies of records.			
Signature of Patient/Patient's Legal Representative		Date	
Relationship to patient: _____			
<i>Supporting documentation of authority must be provided (Guardianship, Executor of Estate, Power of Attorney)</i>			