Mercy
PHYSICAL MEDICINE
AND REHABILITATION
A member of Mercy Medical Center–Des Moines

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

P: 515-358-0150 F: 515-358-0149

Mercy
NEUROSURGERY
A member of Mercy Medical Center–Des Moines

INSTRUCTIONS: Please make sure all blanks are filled in; failure to do so may prevent or delay the release of information.

PATIENT NAME: _____

IDENTIFICATION: Date of Birth: _____ Social Security Number: _____

Previous Name(s): _____

(If under age 18) Parent's Name: _____

PROVIDER NAME: ☐ allow access, use or disclosure of my protected health information to: **OR** ☐ obtain from:

_____

(Who is releasing the information sent?) Address: _____

Phone: _____ Fax: _____

INFORMATION: Date of Service: (from) _____ (to) _____

- ☐ Complete Records
- ☐ Lab Data
- ☐ EKG
- ☐ History & Physical
- ☐ Immunization Record
- ☐ X-ray Data
- ☐ Discharge Summary
- ☐ Other _____

PURPOSE:

- ☐ Transfer of Medical Care
- ☐ Insurance Coverage
- ☐ Moving
- ☐ Other _____

Mercy Physical Medicine and Rehabilitation and/or Mercy Neurosurgery will not condition treatment on your signing this authorization unless: (1) you are receiving research-related treatment, or (2) 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).

Specific Authorization for Release of Information is Protected by State or Federal Law

I specifically authorize the release of data and information relating to:

- ☐ Substance abuse (alcohol/drug)
- ☐ Mental Health (includes psychological testing)
- ☐ HIV-related information (AIDS-related testing)

The authorization is effective for one (1) year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Mercy Physical Medicine and Rehabilitation and/or Mercy Neurosurgery. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Mercy Physical Medicine and Rehabilitation and/or Mercy Neurosurgery. The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Mercy Medical Center – Des Moines Notice of Privacy Practices.

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to Patient (if not signed by patient): _____ Witness: _____

For Office Use Only: Patient identification verified ☐ Yes ☐ No

Date Information Sent: _____ Person Releasing Records: _____ Physician: _____

PROHIBITION OF REDISCLOSURE

Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42.C.F.R. Part 2) and state requirements (Iowa Code ch. 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. I understand all other information used and/or disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

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