Mercy

Mercy Clinic Women's Health
755 Dunn Road, Suite 150
Hazelwood, MO 63042
phone 314-801-5300
fax 314-801-5320

Mercy Clinic Women's Health
1820 Zumbehl Road, Suite 120
St. Charles, MO 63303
phone 314-801-5300
fax 314-801-5320

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification	
Printed Name:	Date of Birth:
Address:	SSN:
	Telephone:

Information is to be released by:	**Information is to be sent to:**
(Physician or Facility)	(Individual/ Agency/ Facility)
(Street Address)	(Street Address)
(City, State, and Zip Code)	(City, State, and Zip Code)
(Telephone Number)	(Telephone Number)

Information To Be Released – Covering the Periods of Health Care	
From (date)	To (date)

Please check type of information to be released:		
☐ Complete health record	☐ Diagnosis & treatment codes	☐ Discharge summary
☐ Laboratory test results	☐ Complete billing record	☐ X-ray films / images
☐ Other (specify)		

Purpose of Request		
☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment
☐ Other (specify)		

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check One:*** ☐ **Yes** ☐ **No**

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, you have the right to revoke this Authorization by submitting a notice in writing to the Department of HIS or other Department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event _____ , or 90 days from date of signature, unless otherwise specified.

Re-release

I understand the information released pursuant to this Authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

Your provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. By signing below, you authorize your provider, identified above, to release your protected health information specified above.

Signature:	Date:
Authority to Sign - if not patient:	Witness:
Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify:	
ID Verified by:	