Mercy
HEALTH SERVICES

Authorization for Disclosure of Protected Health Information (PHI)

Specific Provider or Medical Facility *(List all requested providers and facilities)*

Patient Last Name	**Patient First Name**	**Patient Middle Initial**
Social Security Number	**Date of Birth**	**Medical Record Number**
Street Address	**City**	**State/Zip Code**
Home Phone Number	**Work Phone Number**	**Mobile Phone Number**

I, the undersigned, hereby authorize the above named provider or medical facility to disclose in writing to the individual, entity, facility, or company named below my PHI contained in my medical record. I further authorize the above named provider or medical facility to disclose my PHI electronically and/or discuss my PHI verbally with the individual, entity, facility, or company named below. I hereby authorize the disclosed PHI to include (check ALL that apply):

	Bills		Nurse's Notes
	Claims		Operative Reports
	EKG/Catheterization Reports		Physician Orders
	Emergency Room Records		Progress Notes
	Hospital Discharge Summary		Radiology Films/Imaging
	History and Physical		Radiology Reports
	Laboratory Reports		ANY AND ALL RECORDS

Please release records covering the time period (MM/DD/YYYY to MM/DD/YYYY): _____ to _____

Information to be disclosed to:
(Name and address of the individual, entity, facility, or company to receive my PHI) _____

Purpose of disclosure: _____

The PHI provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol and substance abuse, communicable diseases (including (HIV/AIDS) and/or genetic marker information.
I understand and agree to the following:

- Mercy Health Services does not condition health care treatment I am otherwise entitled to on whether I sign this authorization.
- I understand that the medical records to be accessed may contain medical information pertaining to psychiatric, drug, and/or alcohol, HIV/AIDS diagnosis and treatment.
- This authorization will expire one (1) year after the date of my signature below unless a shorter time period is stated here _____. (Must be a time period or date, not an event or condition).
- Information used or accessed under this authorization may be re-disclosed by the recipient and no longer protected by federal law but may be protected under Maryland law.
- I am free to revoke this authorization at any time by submitting a written request to the entity/provider disclosing the PHI. Any uses or disclosure of my PHI prior to receipt of the revocation cannot be reversed and will not be covered by the revocation.

Signature of Patient (or Legally Appointed Representative) _____ **Date** _____ **Printed name of Legally Appointed Representative** (if applicable) _____

Documentation establishing authority of Legally Appointed Representative
(Duly appointed Personal Representative, Health Care Power of Attorney, Advanced Directive, Parent of Minor Child, etc.)