



**MERCY HEALTH CENTER**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

I am the \_\_\_\_\_ Patient, \_\_\_\_\_ Guardian, \_\_\_\_\_ Parent of Minor Child, \_\_\_\_\_ Personal Representative and hereby authorize Mercy Health Center personnel to disclose medical information on the above named patient to:

Release To: (Name/Facility): \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Purpose of disclosure: \_\_\_\_\_

Date(s) of admission/treatment: \_\_\_\_\_

Information requested: (Copies will be provided at 1.00 for the first page and .50 cents for each additional page. Radiology film copies will be provided at \$5.00 per sheet.)

- |                               |                             |                              |                            |
|-------------------------------|-----------------------------|------------------------------|----------------------------|
| _____ Face Sheet              | _____ Emergency Room report | _____ EEG Report(s)          | _____ History and Physical |
| _____ Operation Report(s)     | _____ Pathology Report      | _____ Consultation Report(s) | _____ Discharge Summary    |
| _____ Physician's Orders      | _____ Progress Notes        | _____ EKG Report(s)          | _____ Radiology films      |
| _____ Laboratory Reports(s)   | _____ Radiology Report(s)   | _____ Pathology slides       | _____ UB/1500              |
| _____ Complete medical record | _____ Other _____           | _____                        | _____ Itemized Bill        |

**I understand that this authorization will automatically expire 6 (six) months from the date of my signature. I also understand that this authorization can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization. To cancel this authorization, send a written request to Health Information Management Department, 4300 W Memorial Road, Oklahoma City, OK 73120.**

Information in your medical record that you have or may have a communicable or noncommunicable disease is made confidential by law and cannot be released without your permission except in limited circumstances, including release to persons who have had risk exposures, release pursuant to an order of the court or the Department of Health, release among health care providers involved in your care or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless the identifying information is released to you, by an order of the court or the Department of Health or by law.

**I UNDERSTAND THAT THE INFORMATION AUTHORIZED FOR RELEASE MAY CONTAIN INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR NON COMMUNICABLE DISEASE.**

Information release may include alcohol and drug abuse records protected under the Code of Federal Regulations and psychiatric records. Re-disclosure of alcohol and drug abuse records by the recipient is prohibited without specific authorization.

**Mercy Health Center may NOT require that you sign this authorization to receive treatment except for certain research-related treatment.**

\_\_\_\_\_ If checked, the Hospital will receive compensation for its use/disclosure of the information that is the information that is the subject of this authorization.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Patient/Personal Representative

If Personal Representative, describe your authority to sign for the patient:

\_\_\_\_\_ Signature of Witness

\_\_\_\_\_ Relationship to Patient

**Your health information that you have authorized to disclose may be subject to redisclosure by the recipient and no longer subject to protection under the federal privacy regulations.**

Completed authorizations to disclose medical information should be returned to: Mercy Health Center - Health Information Management Department, 4300 W Memorial Road, Oklahoma City, OK 73120.

**HIM USE ONLY:**

REQUESTED	RELEASED		REQUESTED	RELEASED	
_____	_____	Face Sheet	_____	_____	Lab Results
_____	_____	History & Physical	_____	_____	Radiology Report
_____	_____	Discharge Summary	_____	_____	EKG Tracings
_____	_____	Operative Report	_____	_____	EEG Report
_____	_____	Pathology Report	_____	_____	Emergency Room (Date: _____)
_____	_____	Consultation Report	_____	_____	Number of pages
_____	_____	Other: _____			

Information Released by: \_\_\_\_\_ Date: \_\_\_\_\_