AUTHORIZATION FOR THE USE OR DISCLOSURE/RELEASE OF PROTECTED HEALTH INFORMATION

TO: Mercy Hospital
4572 County Road 61

Moose Lake, MN 55767
Fax: 218-485-5555

RE: Patient Name: ____________________
(Other Names) ____________________ DOB:
MR#: ____________________

The undersigned hereby authorizes the facility listed above to:

☐ disclose to: ____________________
☐ obtain from: ____________________
☐ disclose and obtain with: ____________________

the following confidential oral and written information from the records of the patient identified above:

☐ History & Physical	☐ X-ray Report(s)
☐ Discharge Summary	☐ Complete Medical Record
☐ Operative Report(s)	☐ Bills and/or Statements/Face Sheet
☐ Pathology Report(s)	☐ EKG
☐ Consultation Report(s)	☐ Medication Records
☐ Laboratory Report(s)	☐ Other

for the following medical condition or injury: ____________________

occurring on or about: ____________________ [date(s)]

for the purpose(s) of:

☐ Continuing Care	☐ Litigation
☐ Insurance Claim(s)	☐ Other (Explain): ____________________

Any and all medical records, including chemical dependency treatment records, psychiatric records, and/or records relating to communicable diseases such as HIV, AIDS and sexually transmitted diseases.

I understand that if the person or entity that receives the information is not covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I do not authorize further release to any third party and hereby release the hospital, clinic, their employees and my physician(s) from any and all liability arising directly or indirectly from such redisclosure.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by Written notification to Mercy Hospital except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this

authorization expires on the following date, event or condition: ____________________
If not specified, this authorization expires in one year.

____________________ Signature of patient or legal representative

____________________ Date

____________________ Relationship to patient, if other

____________________ Signature of Witness

ID of requestor verified? ☐ Method: ____________________ Who verified? ____________________

Records Released: ____________________ (Date) ____________________ (by-full name)

Keep Original – Send Copy *ROI* Revised 5/2005