Authorization for Release of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____SSN:_____

_____Telephone:_____

Information is to be released by:

_____
(Individual/ Agency/ Facility)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(TelephoneNumber)

Information is to be sent to:

West County Pediatrics
16555 Manchester Road
Wildwood, MO 63040
636-458-5858
Fax 636-458-6510

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	□ Pathology Report	□ Radiology Report
□ Laboratory test results	□ Complete billing record	□ EKG Report
□ Other (specify)		

Purpose of Request

□ Consult/Second Opinion	□ Relocating Out of Town	□ Specialist Care
□ Change of Insurance	□ Selecting New Physician (not for insurance reasons)	□ 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 Mercy Medical Group practice 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 practice, 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: _____