MERCY
IOWA CITY

Authorization to Release Medical Records from Mercy Clinics

Patient Name: _____ Birth Date: _____

I, _____, hereby authorize:
(Patient/Guardian)

(From) _____
(Name of person or institution)

To release medical information via copies, viewing, or verbal to:

(To) _____
(Name of person or institution)

_____
(Address)

_____
(Address) (Phone) (Fax)

Check the information to be disclosed: ❑ All records or Specify (include dates if necessary. If no date indicated the last 3 years will be sent):

❑ Allergy List	_____	❑ Billing Information	_____
❑ Consult Reports	_____	❑ Discharge Summary	_____
❑ History and Physical	_____	❑ Immunization Record	_____
❑ Laboratory Results	_____	❑ Medication List	_____
❑ Problem List	_____	❑ X-Ray and Imaging Reports	_____

❑ Other, specify: _____

I understand that information to be released may contain information in the following categories unless I specifically deny the release. (**Initial any category NOT to be released**)

1. Substance Abuse (Drug/Alcohol abuse & testing) _____
2. Mental Health/Depression (includes psychological testing) _____
3. HIV- Related information (AIDS related testing) _____

Please provide reason for release: ❑ 2nd Opinion ❑ Insurance ❑ Legal
❑ Moving out of area ❑ Transfer Care ❑ Other Medical Care

📖 I may revoke this authorization at any time by sending written notice to the above address of the provider/clinic. I understand that any release made which has been made prior to my revocation of which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I also understand that recipients of this information may possibly release the information without proper authorization, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the Health Information Department at the above named clinic. Mercy Services does not require completion of this form as a condition of evaluation or treatment. However, when the evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to the third party is not provided, it may result in the cancellation of those services. This authorization will expire one year from the date of signature, or as indicated _____ (specify number of days or months) unless cancelled by patient/guardian. I also understand that there could be a medical records fee plus postage if mailed.

_____
Signature of Patient or Legal Guardian Date

_____
Address City State Zip

_____
Relationship to Patient Witness