Mercy Hospital and Medical Center
2525 S Michigan Avenue, Chicago, IL 60616
Phone: 312-567-2104 Fax: 312-674-8561

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**SECTION 1: Patient Information** (please print and complete ALL fields)

First Name: _____ Last Name: _____ Date of Birth: _____/_____/____

Address: _____City/State/ZIP: _____ Phone: _____

**SECTION 2: Information Requested** (please check all appropriate boxes)
The SPECIFIC type of information to be used or disclosed ("all records" or incomplete dates are NOT considered specific.)

Specify Hospital or Clinic/Physician Location: _____

☐ Complete Medical Records ☐ ER Records ☐ Discharge Summary ☐ History & Physical ☐ Physical Therapy Notes ☐ Lab Results ☐Path Reports
☐ Radiology Reports ☐ Radiology Images (CD) ☐ Cardiology/EKG/Echo Reports ☐ Operative Reports ☐Immunizations ☐ Billing Statement
☐Other: _____

Include the following **sensitive records:** ☐ Mental Health ☐ HIV/AIDS/STD ☐ Genetic Testing ☐ Drug/Alcohol Abuse
**Witness signature required in Section 6 for the release of these sensitive record types; for a minor aged 12-17 the minor's signature is required in Section 6 for the release of Mental Health, HIV/AIDS/STD or Drug/Alcohol Abuse records.**

For the following dates of treatment: _____
(Examples: specific date - 1/25/2013; range of dates - January-July 2014)

**SECTION 3: I authorize Mercy Hospital & Medical Center to release the above patient records to:**

Name of Individual/Organization: _____ Phone: _____

Address: _____ City/State/ZIP: _____ Fax: _____

**SECTION 4: Method of Delivery (e-Delivery excludes radiology images)**

☐ Fax ☐ U.S. Mail ☐ Secure e-Delivery Email Address: _____

☐ Call for pickup by patient or legal representative (***A photo ID is required for pickup***)

**SECTION 5: Purpose of Disclosure (Records may be subject to charges)**

☐ Continuation of Care ☐ Personal Reasons ☐ Insurance ☐ Transfer of Care ☐ Legal ☐ Other: _____

**SECTION 6: Signatures**

- I understand I have the right to revoke this authorization in writing at any time by sending revocation to Mercy Hospital & Medical Center, 2525 S. Michigan Avenue, Chicago, Illinois 60616**.** The revocation will not apply if Mercy Hospital & Medical Center has already acted in reliance on the authorization.
- I understand this authorization will expire in 90 days or upon the following specified date or event: _____
- I understand information disclosed may be subject to redisclosure by the recipient and may no longer be protected by law.
- I understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.
- I understand I have the right to refuse to sign this authorization, and Mercy Hospital & Medical Center does not condition treatment on this authorization, except disclosure necessary for payment of claims (excluding psychotherapy notes) or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g. pre-employment or life insurance physicals).

**I HEREBY ACKNOWLEDGE I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS AND CONSENT TO THE RELEASE OF RECORDS.**

Patient Signature: _____ Date: _____

Representative Signature (for minors, etc.):_____Relationship: _____ Date: _____

Witness Signature:_____ Date:_____
(Witness signature required for any sensitive records to be released if so selected in Section 2.)