Mercy
MEDICAL CENTER
DES MOINES
*A member of Mercy Health Network*

Mercy Medical Center
1111 6th AVENUE • DES MOINES, IA 50314
PHONE: 515-633-3915 • FAX: 515-633-3851

# Authorization/Request for Release of Medical Information

| **Instructions** | **Make sure all blanks are filled in. Failure to do so could prevent or delay processing** |
|---|---|
| **PATIENT INFORMATION** | Name (Legal/Maiden/Other)____________________<br>Address:____________________<br>City:____________ State:_____ Zip:________<br>Phone:____________ Date of Birth: ____________ |
| **RELEASING ENTITY**<br>(Who is authorized to release the information) | Provider Name:____________________<br>Address:____________________<br>City:____________ State:______ Zip ____________<br>Phone:____________ Fax____________ |
| **RECEIVING ENTITY:**<br>(Where do you want the information sent) | Requestor Name:____________________<br>Address:____________________<br>City:____________ State: ______ Zip:____________<br>Phone:____________ Fax:____________ |
| **INFORMATION REQUESTED**<br>(Charge may apply) | Service Dates:____________________<br>❑ Abstract ( all physician dictations/test results)<br>❑ Entire Record ❑Laboratory ❑ Immunization Record<br>❑ EKG/Cardiology Testing ❑ Radiology ❑ Discharge Summary<br>❑ History & Physical ❑ Other____________________ |
| **PURPOSE OF RELEASE**<br>(Check all that apply) | ❑ Continued Care ❑ Insurance ❑ Legal<br>❑ Moving ❑ Personal ❑ Transferring Care<br>❑ Other____________________ |
| **REQUESTED FORMAT** | ❑ Paper ❑ CD (Password Protected) ❑ Mailed<br>❑ Faxed to:____________ ❑ Other: (please specify)____________<br>❑ Email to:____________________<br>❑ Call ____________ at (phone #)____________ Pick up Date____________ |

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***** SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW*****

**PLEASE CHECK EITHER YES OR NO IN EACH APPLICABLE LINE TO RELEASE THE SPECIFIC INFORMATION:**

Substance Use/Abuse ❑ YES ❑ NO    Mental Health ❑ YES ❑ NO

STD /HIV-related information ❑ YES ❑ NO    Genetic Information ❑ YES ❑ NO

___________________________________________ __________________

Signature of Patient or Legal Representative    Date

__________________________________________

Relationship to Patient, if not signed by Patient

**Prohibition on Conditioning of Authorization:** Mercy Medical Center, Mercy Clinics or Iowa Heart Center will not condition treatment, payment or enrollment/eligibility for benefits on signing this authorization unless:

- You are receiving research-related treatment or
- The only reason the facility is providing you with health care is to make a report to a third party such as your employer(e.g., fitness to return to work) or school (e.g., athletic participation.

**EXPIRATION:** This authorization is effective for ______________ months but no longer than one year from the date on which it was signed.

**REVOCATION:** I understand I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving a written notice.

**INSPECTION:** I understand I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Mercy Medical Center, Mercy Clinics and Iowa Heart Center.

**PLEASE BE AWARE THERE MAY BE A FEE ASSOCIATED WITH YOUR REQUEST**

The statement made in this authorization are binding, controlling and I understand that they take precedence over statements in the organization Notice of Privacy Practices.

Signature of Patient or
Legal Representative: ____________________________________________ Date: ___________________

Relationship to Patient,
If not signed by Patient: ___________________________________________ Witness: ________________

PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2) and state requirements (Iowa Code, ch 228). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

**OFFICE USE ONLY:**

Medical Record #:______________________    Account #: ____________________________

Date Information Sent: _______________ Person Releasing Records: __________________

Fee Due: _____________________ Fee Paid: _________________________________