Mercy
RIVER HILLS
SURGERY CENTER

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFOMRAITON

(please print)

Patient Name: _____ Acct# _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Address: _____ Phone (home): _____

City/State/Zip: _____ Phone (work/cell): _____

I the undersigned authorize and request Mercy River Hills Surgery Center to allow access, use, or disclosure of my protected health information to:

Person/Organization: _____

Address: _____ Phone: _____

City/State/Zip: _____ Fax: _____

Please select why you are granting access to the protected health information:

☐ Continuing Medical Care ☐ Insurance ☐ Personal ☐ Legal ☐ Other(explain):_____

Releasing Health Records for dates of treatment I received from (date) _____ through(date) _____

I understand that the provider may or may not grant access to my records. In any event this request will be made part of my permanent health record.

If request is accepted please check the documents you wish to have photocopied for disclosure:

☐ All Records ☐ Images ☐ History&Physical (H&P) ☐ EKG,EEG, Other test results
☐ Discharge Summary ☐ Labs ☐ Operative Report ☐ Pathology Report
☐ Other: _____

*** **I specifically authorize the release of records that may include protected information regarding**:

☐ Drugs or alcohol use/abuse ☐ Mental Health ☐ HIV/AIDS

Information is to be released to Person/Organization listed above by:

☐ Mail ☐ Fax ☐ For Pick-up Call _____ at Phone# _____

Patient may inspect or receive a copy of the PHI to be used or disclosed, if applicable.

Mercy River Hills may impose a fee to cover the cost of labor, copying, postage, and/or preparing a summary of the requested information. Do you agree to such fees? ☐ YES ☐ NO

Prohibition on Conditioning of Authorization: Mercy River Hills will not condition treatment on your 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

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, Federal Law (42 CFR Part 2) for Alcohol/Drug abuse and State Law (Iowa Code ch. 228 & 141) for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the Release of Medical or Other Information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Civil and Criminal Penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS information.

Expiration: This authorization is effective until _____ (month/day/year) or expiration of event (e.g. completion of a course of treatment or end of research study) but no loner than 1 year from the date on which it was signed.

Revocation: I understand that I may revoke this authorization at any time by notifying Mercy Rive Hills in writing by sending a letter to Mercy River Hills Surgery Center Compliant Privacy Officer 450 Laurel St. Suite D Des Moines, IA 50314 or completing the Revocation for Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Mercy River Hills Surgery Center took before It received my revocation letter.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Mercy River Hills Surgery Center's Notice of Privacy Practices.

Signature (Patient or Personal Representative) _____ Date: _____

Relationship to Patient: _____

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For Mercy River Hills Surgery Center Use Only:

Patient Identification Verified ☐ YES ☐ NO Received by: _____ Date: _____

Request accepted ☐
Denied ☐