AUTHORIZATION FOR THE RELEASE OF PATIENT PROTECTED HEALTH INFORMATION (PHI)

GENERAL INFORMATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules, I request:

- ❑ To inspect/review my PHI (with prior approval of Health Information Management Dept.)
- ❑ To obtain a copy of my PHI as described below
- ❑ To release a copy of my PHI as described below.

Please print the following information: **MRN:** ______________________

Patient Name: ____ **Date of Birth:**____________________

Social Security Number: ________-_________-________ **Phone Number:** _______-________-__________

Address:____

City:____**State:**_________________**Zip Code:**_____________

REQUEST INSTRUCTIONS

The protected health information described below may be used by or disclosed to the following:

Name of person/organization: ____

Address:____

City:____**State:**_________________**Zip Code:**_______________

Date(s) of Admission/Treatment: ____

- ***Psychotherapy/psychiatric consultation or notes:***
  Is this request for psychotherapy/psychiatric consultation or notes?
  Yes, then this is the only item you may request on this authorization. __________________ ***(Initial)***
  You must submit another authorization for non-psychiatric records below.

- ***Substance abuse records:***
  I authorize and hereby consent to such, that the released information may contain substance abuse records.
  __________________ ***(Initial)***

- ***HIV test results:***
  I authorize and hereby consent to such, that the released information may contain HIV test results.
  ___________________ ***(Initial)***

- ***Please specify the protected health information that you are authorizing to be inspected/disclosed:***

- ❑ **All Medical Records** *(excluding Psychotherapy, HIV/AIDS, Substance abuse treatment)*
- ❑ **Outpatient Medical Records**
- ❑ **Abstract (includes * reports)**
- ❑ ***Emergency Record**
- ❑ ***Face Sheet**
- ❑ ***Discharge Summary**
- ❑ ***History & Physical Exam**
- ❑ **Progress Notes**
- ❑ ***Operative Record**
- ❑ ***Pathology Report**
- ❑ ***Consultation Reports**
- ❑ **Photograph/videotape/digital or other imaging films**
- ❑ **Physician Orders**
- ❑ ***Laboratory Reports**
- ❑ ***Cath Lab**
- ❑ ***EKG/Echocardiogram Reports**
- ❑ **X-ray Reports** *(x-ray films must be obtained from the Radiology Dept.)*
- ❑ **Other:** ________________________

- ***This Authorization will expire (insert date or event)***____
  (if left blank, the Authorization will expire 90 days from date on which it was signed.)

ACKNOWLEDGMENT

I understand that:

- *I have a right to revoke this Authorization at any time, and that if I revoke this Authorization, I must send a written request to: Mercy Hospital, 3663 South Miami Avenue, Miami, FL 33133. Attn: Medical Records Custodian, Health Information Management Department. I understand that the revocation will not apply to information that has already been released in reliance on this Authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.*
- *I understand that this Authorization is voluntary. I understand that once the protected health information described herein is disclosed, it may be re-disclosed by the recipient and may no longer be protected by federal privacy laws; however, under federal and state laws respectively, the recipient may be prohibited from re-disclosing substance abuse, HIV, and psychotherapy/psychiatric consultation or notes without specific written consent of the person to whom it pertains, or as otherwise permitted by such laws.*
- *I understand that I may refuse to sign this Authorization and that my refusal will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits, except that I further understand that Mercy Hospital may condition the provision of research-related treatment, if any, on provision of my authorization for the use or disclosure of my protected health information for such research; that a health plan may condition my enrollment in their plan or my eligibility for their benefits on provision of my authorization as requested by the health plan prior to my enrollment in the health plan if such authorization is sought for the purpose of determining my eligibility or enrollment in the health plan relating to myself or for the health plan's underwriting or risk rating determinations, and that such authorization is not for a use of disclosure of psychotherapy notes; and that Mercy Hospital may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my providing authorization for the disclosure of my protected health information to such third party.*
- *If the information is located on site, Mercy Hospital has 30 days to respond to this request. If the information is not on site, Mercy Hospital has 60 days to respond. An additional 30 days may be requested by Mercy Hospital in order to comply.*
- *I understand that in accordance with Florida Statute 395.3025 that I or the ruesting party may be charged a fee for copying cost to obtain a copy of my PHI or for a summary or summary preparation of PHI.*
- *I have read and understand the terms of this Authorization and have had an opportunity to ask questions about the use and disclosure of my PHI. By my signature, I hereby, knowingly and voluntarily authorize Mercy Hospital to use or disclose my PHI in the manner described above.*
- *I am entitled to a copy of this Authorization after I sign it.*

PATIENT SIGNATURE

______________________________ Patient Name (Print)	Date ________/__________/__________
______________________________ Patient Signature/Health Care Surrogate/Proxy	______________________________ Print Name if Health Care Surrogate or Proxy ______________________________ Relationship to Patient
______________________________ Witness Signature	______________________________ Print name if witness