MERCYONE

Print Patient's First Name ____ M ____ Last Name ____

Date of Birth ____ Sex ____ MRN ____

CSN: _____ or Patient Label

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Printed Patient's Name _____ Phone _____

Patient's Birth Date _____ Email Address _____

Address _____

Address _____ City _____ State ___ Zip _____

DESCRIPTION OF MEDICAL RECORDS REQUESTED:

Please check facility from which you are requesting records –

- ☐ Cedar Falls (Hospital)
- ☐ Centerville
- ☐ Clinton
- ☐ Des Moines (Hospital)
- ☐ Des Moines/Central Iowa (Clinics)
- ☐ Dubuque
- ☐ Dyersville
- ☐ Elkader
- ☐ Newton
- ☐ New Hampton
- ☐ North Iowa
- ☐ Oelwein (Hospital)
- ☐ Quad Cities (Genesis)
- ☐ Waterloo (Hospital)
- ☐ Waterloo Clinic
- ☐ Medical Clinic – Location/Provider _____

List Date(s) of Treatment_ _____

Please select documents to disclose:

- ☐ Emergency Department Report
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultations
- ☐ Operative/Procedure Report
- ☐ Lab Pathology Results
- ☐ Progress Notes
- ☐ Test Results (EKG, EEG, ECHO)
- ☐ X-Ray/Diagnostic Results
- ☐ Summary/Abstract Record Set

Specify Test Result _____

☐ Clinic/Physician Office Notes – Specify Provider Name _____

☐ Other (list) _____

Please include: ☐ Radiology Images/CD ☐ Itemized Billing Records ☐ Completed Medical Record (Fees may apply)

PURPOSE OR NEED FOR THE DISCLOSURE IS:

☐ Continued Medical Care ☐ Insurance/Payment ☐ Legal Reasons ☐ Patient's Own Use

☐ Other (list) _____

PLEASE DISCLOSE REQUESTED RECORDS TO:

I authorize the medical records indicated above to be provided to the following:

☐ Patient/Myself ☐ Parent/Legal Guardian ☐ HIPAA Personal Representative ☐ Other, specify below:

Name _____

Address _____

Phone _____ Fax _____

FORMAT REQUESTED: (check only one option)

☐ Deliver to Patient Portal/MyChart ☐ CD ☐ Paper ☐ Inspect a Copy ☐ Email–if you choose email, insert email address and choose secured or unsecured below Email address _____

☐ secured/encrypted email (access instructions provided) ☐ unsecured/unencrypted email*

* If you checked "unsecured email" please be aware that sending and receiving your medical record info via unsecured email creates personal risk of interception and potential identity theft.

* Please initial if you are requesting unsecured delivery via your personal email listed above. Initials _____

** If records are unable to be emailed due to size limitations, please select an alternate format: ☐ Paper or ☐ CD

** Records provided on CD or paper will be sent via the United States Postal Service.

Charges for Access: We will not charge you for your first copy of your pertinent record set and/or outpatient diagnostic test results sent to you, the patient's parent or legal guardian, or your HIPAA personal representative. If you ask us to copy your complete medical record, we may charge a reasonable fee as permitted by HIPAA Privacy regulations. Health Information Management utilizes a copy service to complete most record requests. You may be invoiced directly by the copy service where applicable. You may request to be notified of any charges for approval prior to having your records sent to you.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Information About Your Access Rights: Except under limited circumstances, we will provide you with access to your records. We will respond to your request within 30 days (or 60 days if the extra time is needed to gather records) from the time we receive this completed form. In certain situations, we may deny your request but if we do, we will tell you in writing of the reasons for the denial and explain your rights to have the denial reviewed.

I hereby request access to my health information as noted above maintained by MercyOne. I understand that the disclosure of my health information MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, treatment for alcohol and/or drug abuse, and/or genetic testing.

Please initial below to authorize the disclosure of any of this information:

_____ Alcohol/Drug Abuse or Addiction Diagnosis Treatment

_____ Behavioral/Mental Health Information

_____ Communicable Disease, including Sexually Transmitted Disease

_____ Genetic Testing

_____ HIV/AIDS Related Information, including testing and treatment

_____ Reproductive Records

If I refuse to sign this Authorization the health care provider will not withhold treatment from me and will not disclose the information to the recipient specified above.

I understand that if the recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by the recipient and no longer protected by these regulations.

I understand that I have the right to revoke this authorization by written notice to the health care provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those prior actions.

This authorization expires on _____ *(date)* or upon the following event: _____

(If no date or event is specified, this authorization will expire one (1) year from the date of signature.)

SIGN HERE _____ _____

Signature of Patient, Parent/Legal Guardian, or HIPAA Personal Representative *Date*

Printed name of patient's Parent/Legal Guardian or HIPAA Personal Representative, if applicable _____

Describe relationship to patient (e.g., minor's parent, guardian) _____

Mail request form to:

FACILITY	MAILING ADDRESS	FAX NUMBER	EMAIL
Cedar Falls (Hospital)	515 College St, Cedar Falls, IA 50613	319-268-3963	IAmedicalrecordshosp@mercyhealth.com
Centerville	One St. Joseph's Drive, Centerville, IA 52544	515-633-3851	Trinitymercyoneia@mrowork.com
Clinton	1410 North 4th Street, Clinton, IA 52732	563-244-5576	N/A
Des Moines (Hospital)	1111 6th Avenue, Des Moines, IA 50314	515-633-3851	Trinitymercyoneia@mrowork.com
Des Moines/Central Iowa (Clinics)	405 SW 5th St. Suite F, Des Moines, IA 50309	515-358-6996	N/A
Dubuque	250 Mercy Drive, Dubuque, IA 52001	563-589-8162	N/A
Dyersville	1111 Third Street Southwest , Dyersville, IA 52040	563-875-2957	N/A
Elkader	901 Davidson St. N.W., Elkader, IA 52043	515-633-3851	Trinitymercyoneia@mrowork.com
Newton	204 North 4th Avenue East, Newton, IA 50208	515-633-3851	Trinitymercyoneia@mrowork.com
New Hampton	308 N Maple Ave, New Hampton, IA 50659	641-394-1999	NHHIM@mercyhealth.com
North Iowa	1000 4th St SW, Mason City, IA 50401	641-428-7800	mchimoperations@mercyhealth.com
Oelwein (Hospital)	201 8th Ave SE, Oelwein, IA 50662	319-283-6061	IAmedicalrecordshosp@mercyhealth.com
Quad Cities (Genesis)	1401 West Central Park, Davenport IA, 52804	563-421-4289	GHS_release@mercyone.org
Waterloo (Hospital)	3421 W. Ninth St. Waterloo, IA 50702	319-272-7810	IAmedicalrecordshosp@mercyhealth.com
Waterloo (Clinic)	2710 St. Francis Dr, Waterloo, IA 50702	319-272-5382	WOHssharedmdmedicalrecordsclin@mercyhealth.com

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request these records. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavits of Heir at Law, etc. HIPAA personal representative is defined as a person with legal authority to make health care decisions on behalf of the individual.

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