



**AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION (PHI)**

| | | |
|-----------------------------------|-----------|-----------------|
| Print Patient's First Name _____ | M _____ | Last Name _____ |
| Date of Birth _____ | Sex _____ | MRN _____ |
| CSN: _____ or Patient Label _____ | | |

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) | Cedar Falls (Clinic) | Centerville | Clinton |
| Clinton (Clinic) | Des Moines (Hospital) | Des Moines/Central Iowa (Clinics) | Dubuque |
| Dyersville | Elkader | Newton | New Hampton |
| North Iowa | North Iowa (Clinic) | Oelwein (Hospital) | Oelwein (Clinic) |
| Quad Cities (Genesis) | Quad Cities (Genesis) Clinic | 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 Complete Medical Record (Fees may apply)

PURPOSE OR NEED FOR THE DISCLOSURE IS:

Patient's Own Use Continued Medical Care Third Party (Insurance, Legal)

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 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.



HIMROI

| | | |
|----------------------------|-----|------------------|
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| Date of Birth | Sex | MRN |
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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:

- | | |
|--|---|
| <input type="checkbox"/> Alcohol/Drug Abuse or Addiction Diagnosis Treatment | <input type="checkbox"/> Behavioral/Mental Health Information |
| <input type="checkbox"/> Communicable Disease, including Sexually Transmitted Disease | <input type="checkbox"/> Genetic Testing |
| <input type="checkbox"/> HIV/AIDS Related Information, including testing and treatment | <input type="checkbox"/> 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 _____
Patient Signature (Print form, sign by hand, and return. Typed signatures will not be accepted.) 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 |
| Cedar Falls (Clinic) | 2710 St. Francis Dr., Waterloo, IA 50702 | 319-272-5382 | IAmedicalrecordshosp@mercyhealth.com |
| Centerville | One St. Joseph's Drive, Centerville, IA 52544 | 833-521-5846 | TrinityMercyOneIA@mrocorp.com |
| Clinton | 1410 North 4th Street, Clinton, IA 52732 | 563-244-5576 | TrinityClintonIA@mrocorp.com |
| Des Moines (Hospital) | 1111 6th Avenue, Des Moines, IA 50314 | 833-521-5846 | TrinityMercyOneIA@mrocorp.com |
| Des Moines/Central Iowa (Clinics) | 405 SW 5th St. Suite F, Des Moines, IA 50309 | 515-358-6996 | MercyOneIowaClinics@mrocorp.com |
| Dubuque | 250 Mercy Drive, Dubuque, IA 52001 | 563-589-8162 | TrinityDubuque@mrocorp.com |
| Dyersville | 1111 Third Street Southwest, Dyersville, IA 52040 | 563-589-8162 | TrinityDubuque@mrocorp.com |
| Elkader | 901 Davidson St. N.W., Elkader, IA 52043 | 515-220-7062 | Trinityelkaderia@mrocorp.com |
| Newton | 204 North 4th Avenue East, Newton, IA 50208 | 833-521-5846 | TrinityMercyOneIA@mrocorp.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 |
| Oelwein (Clinic) | 2710 St. Francis Dr., Waterloo, IA 50702 | 319-272-5382 | IAmedicalrecordshosp@mercyhealth.com |
| Quad Cities (Genesis) | 1401 West Central Park, Davenport IA, 52804 | 563-421-7289 | trinityhealthgenesis@mrocorp.com |
| 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.

