Authorization for Disclosure of Protected Health Information (PHI)

☐ Mercy Medical Center (Includes Inpatient, Same Day Surgery, Observation, and Emergency Department Visits)
☐ Physician/Provider/Location (fill in name or check off location on page 2): _____

Patient Last Name | Patient First Name | Patient Middle Initial | Patient Phone Number

Social Security Number | Date of Birth | Address

I, the undersigned, hereby authorize the above named provider or medical facility to disclose in writing to the individual, entity, facility, or company named below my PHI contained in my medical record. I further authorize the above named provider or medical facility to disclose my PHI electronically and/or discuss my PHI verbally with the individual, entity, facility, or company named below. I hereby authorize the disclosed PHI to include (check ***all*** that apply):

Items 1 through 5 must be completed.

1. **Check the type of records to be released (check all that apply):**

☐	Inpatient	☐	Emergency Dept.	☐	Detox Unit
☐	Same Day Surgery	☐	Outpatient Testing (lab, radiology)	☐	
☐	Physician Visit	☐	Other (please specify):	☐	

2. **Check specific information to be released (check all that apply):**

☐	Bills	☐	History and Physical	☐	Physician Orders
☐	Consultation	☐	Implant Record	☐	Progress Notes
☐	Demographic Sheet	☐	Laboratory Reports	☐	Radiology Films/Imaging
☐	EKG/Catheterization Reports	☐	Nurse's Notes	☐	Radiology Reports
☐	Emergency Room Records	☐	Operative Reports	☐	Any and All Records
☐	Hospital Discharge Summary	☐	Pathology report	☐	Other (please specify):

3. **Please specify the date(s) of service below**

Date From: MM/DD/YYY or MM/YYYY	**Date to:** MM/DD/YYY or MM/YYYY

4. **The information may be disclosed to and used by the following:**

Name: _____

Address: _____

Phone #: _____ Fax #: _____

FORMAT: I request that the copy be provided (where possible/available)
☐ On paper ☐ Electronically on a password protected CD
☐ Through a web portal, with notice provided to my email account at: _____

5. **The purpose of this disclosure or use is for the following reason:**

☐ Medical ☐ Legal ☐ Disability ☐ Insurance ☐ At the request of the patient ☐ other _____

The PHI provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol and substance abuse, communicable diseases (including (HIV/AIDS) and/or genetic marker information. I understand and agree to the following:

- Mercy Health Services does not condition health care treatment I am otherwise entitled to on whether I sign this authorization.
- I understand that the medical records to be accessed may contain medical information pertaining to psychiatric, drug, and/or alcohol, HIV/AIDS diagnosis and treatment.
- This authorization may include records received from other healthcare providers that are part of my Mercy medical record.
- This authorization will expire one (1) year after the date of my signature below unless a shorter time period is stated here _____. (Must be a time period or date, not an event or condition).
- Information used or accessed under this authorization may be re-disclosed by the recipient and no longer protected by federal law but may be protected under Maryland law.
- I am free to revoke this authorization at any time by submitting a written request to the entity/provider disclosing the PHI. Any uses or disclosure of my PHI prior to receipt of the revocation cannot be reversed and will not be covered by the revocation. Please send written request to the Health Information Services Department at Mercy Medical Center.

Signature of Patient (or Legally Appointed Representative) | **Date** | **Printed name of Legally Appointed Representative** (if applicable) **Relationship to Patient**

Documentation establishing authority of Legally Appointed Representative
(Duly appointed Personal Representative, Health Care Power of Attorney, Advanced Directive, Parent of Minor Child, etc.)

Mercy
HEALTH SERVICES

Below is a listing of Mercy Health Services locations. This is not an all-inclusive. Please use this to assist you on filling in the Physician/ Provider/Location. For additional information on Mercy Physicians and Centers please see our website at https://mdmercy.com/.

Check all that apply

☐ Breast Reconstruction and Restoration	☐ Orthopedics and Joint Replacement
☐ Business Health Services	☐ Overlea Radiology/Imaging
☐ Center for Advanced Fetal Care	☐ Plastic and Reconstructive Surgery
☐ Center for Restorative Therapies	☐ Rheumatology
☐ Cosmetic Medicine and Surgery	☐ Sebastian John, M.D.
☐ Dermatology	☐ SPPS Metropolitan
☐ Downtown OB/GYN	☐ The Bose Medical Group
☐ Dr. Sheila Alongi	☐ The Center for Endocrinology
☐ Employee Health Services	☐ The Center for Interventional Pain Medicine
☐ Fausto Aquino, M.D.	☐ The Center for Minimally Invasive Surgery
☐ Hoffman & Associates	☐ The Center for Restorative Therapies
☐ Hunt Valley Family Health	☐ The Gynecologic Oncology Center
☐ Institute for Digestive Health & Liver Disease	☐ The Heart Center
☐ Institute for Gynecologic Care and Oncology	☐ The Hoffberger Breast Center
☐ Lutherville Radiology/Imaging	☐ The Institute for Cancer Care
☐ Maryland Family Care Physicians/Downtown Pediatrics	☐ The Institute for Foot and Ankle Reconstruction
☐ Medical Oncology/Hematology	☐ The Lung Center
☐ Mercy Anatomic Pathology	☐ The Maryland Bariatric Center
☐ Mercy Medical Center	☐ The Maryland Spine Center
☐ Mercy Personal Physicians in Columbia	☐ The Minimally Invasive Brain and Spine Center
☐ Mercy Personal Physicians in Lutherville	☐ The Neurology Center
☐ Mercy Personal Physicians in Reisterstown	☐ The Shoulder, Elbow, Wrist and Hand Center
☐ Mercy Personal Physicians in Downtown	☐ The Urology Specialists of Maryland
☐ Mercy Personal Physicians in Glen Burnie	☐ The Vascular Center
☐ Mercy Personal Physicians in Overlea	☐ Transitional Care Unit
☐ Mercy Radiology/Imaging	☐ Other (please specify):_____