General Authorization to Use or Disclose Health Information

Mercy Fitzgerald Hospital   Mercy Philadelphia Hospital   Nazareth Hospital   Mercy LIFE   Mercy Physician Practices

Patient Name: ______________________   Phone #: ______________________

Date of Birth: __________   SS # (last 4 digits): __________   Medical Record #: __________

1. I authorize the use or disclosure of the above named individual's health information as described below

2. The following individual(s) or organization(s) are authorized to make the disclosure: ______________________

3. The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)

Date(s) of Service: ______________________

Face Sheet/Registration Sheet	Lab Results	Radiology Results:
Discharge Summary	Medication List	On CD On film On paper
ER Record	Discharge Instructions	OTHER (specify): __________
H&P	EKG/Cardiology Testing Results	
Consults	Home Care Records	Behavioral Health Information ____ **Initial**
Progress Notes	Entire Record	Substance Abuse Information ____ **Initial**
Operative Report	Pathology Report	Human Immunodeficiency Virus (HIV) Information ____ **Initial**

4. I understand that if my authorization includes Behavioral Health, substance abuse or HIV information, it may include; (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) - related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and alcohol abuse control act of 1972 - act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures act 1976, section 5100.3-39).

5. The information identified above may be used by or disclosed to the following individual or organization(s):

Name: ______________________

Address: ______________________

6. This information for which I'm authorizing disclosure will be used for the following purpose:

Sharing with other health care providers as needed   Other (please describe):

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. An oral request for revocation can be accepted in special circumstances.

8. This authorization will begin on the date signed below and expire on __________. If no expiration date is specified, this authorization will expire one year from the signature date.

9. With the exception of Behavioral Health, substance abuse or HIV information, once your health information is disclosed, it may be re-disclosed by the recipient and may no longer be subject to state or federal law protections. Any information disclosed containing Behavioral Health, substance abuse or HIV information is protected under State regulations limiting the recipient's right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

______________________   __________   ______________________

Signature of patient or health care agent/representative   Date   Relationship to patient, if signed by health care agent/representative

______________________   __________

Signature of witness   Date

Verbal Consent: The patient has given verbal authorization to release the above identified information. I have witnessed the verbal authorization. The patient has been informed of the nature of the authorization and freely gives his/her consent.

Signature of witnesses 1. ______________ 2. ______________ Date: __________

I have been offered a copy of this Authorization Form	Accept	Refuse
Patient (or agent/representative) identification verified	Yes	No
I would like to receive the records requested in an electronic format	Yes	No

Email address (if applicable): ______________________

Mercy Health System

A Member of Trinity Health