Cleveland Clinic
Mercy Hospital

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

F-0404-NS 840 0604

Unit Number:

Name: _____

Address: _____

_____

Telephone No.: _____

Birthdate: _____/_____/_____ S. S. No. _____

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

Organization making disclosure: _____

Information may be disclosed to: _____

Address: _____
(Street) (City) (State) (Zip Code)

for the purpose of _____ dates of visit _____ .

Place an (x) to indicate the information to be released:

- ☐ Demographic Form
- ☐ Discharge Summary
- ☐ Emer. Dept. Report: ___/___/___
- ☐ History - Physical Exam
- ☐ Physicians' Orders
- ☐ Consultation Report
- ☐ Progress Notes
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ EKG Report (Cardiac Diagnostics)
- ☐ Neurodiagnostics
- ☐ Vascular Lab
- ☐ Therapy Reports
- ☐ Medications & Treatments
- ☐ Nurse's Notes
- ☐ Clinical Sheets
- ☐ Photographs
- ☐ Other _____

I understand that I have the right to revoke this authorization at any time by sending a written revocation to Mercy Medical Center Health Information, 1320 Mercy Drive, NW, Canton, OH 44708. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date (60 days if not specified), event, or under the following condition:

_____.

I understand that authorizing the disclosure of this health information is voluntary and the Medical Center will not condition the provision of treatment or payment to me on the signing of this authorization, except for the provision of research related treatment to me in the signing of this authorization for the use or disclosure of my personal health information for such research.

I understand that authorizing the disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I understand that my health record may include information related to alcohol and/or drug dependence abuse, behavioral or mental health conditions, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). This release is sufficient for release of drug/alcohol diagnosis and treatment (42 CRF.Part 2) and HIV test results or diagnosis (ORC 3701.243).

_____ _____
Patient or Representative Date

_____ _____
Relationship to Patient Witness

Records reviewed and/or copies
received by: _____

No. Copies Sent: _____
Authorization Given: _____
Employee Initials: _____
Date: _____