Mercy Clinic OB/GYN
10777 Sunset Office Dr. | Suite 200
St. Louis, MO 63127
314-842-4802 | fax 314-849-8721

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification	
Printed Name:	Date of Birth:
Address:	SSN:
	Telephone:

Information To Be Released / Purpose	
I authorize Mercy Clinic staff and physicians to speak with my parent, guardian or other individual (listed below) for the purpose of my medical care and treatment and to share any and all of my protected health information in discussions with them.	
Mother:	DOB:
Father:	DOB:
Guardian/Other:	DOB:

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually-transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, you have the right to revoke this authorization by submitting a notice in writing to the Department of HIS or other Department to whom you are authorizing disclosure. Unless revoked, this authorization will expire on the following date or event: termination of my treatment relationship with the above provider.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure	
I understand that I do not have to sign this authorization. My health care provider will not deny treatment, payment, enrollment, or the eligibility for benefits if I do not sign this form. I can inspect or copy the protected health information to be used or disclosed.	
Signature:	Date:
Authority to Sign - if not patient:	Witness: