Mail ☐ Pickup ☐

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I authorize Mercy Health, on behalf of HealthSpan Integrated Care and/or HealthSpan Physicians, LLC ("HealthSpan"), to disclose and/or receive for use the following information for the individual named below (Please print):

Patient Name: _____HealthSpan Medical Record #: _____

Address: _____

City/State/Zip: _____

Phone #: (_____)_____ Date of Birth _____

2a. **I AUTHORIZE** *(name of where records coming from)*:

Mercy Health on behalf of HealthSpan
Atten: Health Information Services
3700 Kolbe Road
Lorain, Ohio 44053
Fax # (440)960-4635
e-mail: OHMedcorresp@mercy.com

Phone: (440) 960-3320

2b. **TO RELEASE TO** *(name of where records going to)*:

_____
Name of receiving person/organization

_____
Street Address

_____
City State Zip Code

Phone: (_____)_____

Email[1]:_____

3. At my request the following information may be disclosed and/or used : *(Specify dates where appropriate)*

☐ Immunizations
☐ Medical Record *Date(s):*_____
☐ X-Ray Reports *Date(s):*_____
☐ Other Records *Date(s):*_____
(specify type) _____

☐ Laboratory Results *Date(s):*_____
☐ HIV/AIDS Test Results *Date(s):*_____
☐ Mental Health Record *Date(s):*_____
☐ [1]Electronic copy of electronic health record:
(Please provide email address in 2b and complete E-delivery Form)

4. For the purpose of: *(check all that apply)*

☐ Continuity of Care ☐ Personal Use ☐ Consultation ☐ Insurance Claim
☐ Form Completion ☐ Attorney Inquiry ☐ Social Security ☐ Workers' Comp
☐ Eligibility/Enrollment ☐ Rate Setting ☐ Employer Request ☐ Appeals
☐ Other (Specify) _____

Signatures and dates must be on Page 2 for this authorization to be valid.

Revised 1/22/2015

Patient Name: _____
HealthSpan Medical Record #:_____
Date of Birth: _____

5. I understand that the information released upon authority of this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse, HIV/AIDS test results, diagnoses or treatment of HIV/AIDS, and past medical history information.

6. This authorization will expire one year from the date of signing pursuant to Ohio Revised Code 3701.74(B). I understand that I have a right to revoke this authorization in writing at any time and must submit my written revocation to Mercy Health Attention: Health Information Services, 3700 Kolbe Road, Lorain, Ohio 44053. I understand that the revocation will not apply to any actions taken in reliance on this authorization. Revocation of an authorization used to secure a policy of insurance, including health insurance from a HealthSpan entity, may not be permitted during the period of time the insurer may contest the policy issued or a claim under the policy

7. I understand that Mercy Health and HealthSpan may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on my execution of this authorization, except when HealthSpan seeks authorization (1) because it is providing research-related treatment; (2) for purposes of determining health plan eligibility, enrollment underwriting, or risk rating, so long as the authorization is not for use or disclosure of HIPAA psychotherapy notes; or (3) because it is providing treatment solely for the purpose of creating protected health information for the disclosure to a third party.

8. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and is not protected by the Mercy Health or HealthSpan policy or the HIPAA Privacy Rule.

9. I understand that I (or person authorized to act as my representative) am entitled to receive a copy of this authorization.

By signing this form below, you are authorizing the release of the requested information identified above. If the person signing is not the member/patient indicate the relationship to the member/patient and attach supporting authorization or legal documentation.

_____ _____
X Signature of Patient or Authorized Personal Representative[1] Date

_____ _____
Authorized Personal Representative's Name Relationship to Patient

10. I understand that a reasonable fee may be charged for duplication of records and accept full financial responsibility for that fee. Mercy Health may use a contracted service to process this request.

_____ _____
X Signature of Patient or Authorized Personal Representative[1] Date

_____ _____
Printed Authorized Personal Representative's Name Relationship to Patient

Signatures and dates must be on Page 2 for this authorization to be valid.

(1) Authorized Personal Representative is a person who has legal authority to act for an individual in making decisions related to the individual's health care or for a deceased individual or the deceased's estate. The personal representative can be a person who has been designated by the individual (e.g., Power of Attorney) or otherwise has legal authority (e.g., by operation of law, such as a parent; by court appointment).