MOUNT CARMEL
Medical Group

AUTHORIZATION FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Printed Patient's Name: _____ Phone: _____

Patient's Address: _____ City, State & Zip Code: _____

Patient's Date of Birth: _____ Patient's Social Security Number (last 4 digits): XXX – XX –_____

ORGANIZATION AUTHORIZED TO RELEASE MEDICAL INFORMATION:

Name:_____

DESCRIPTION OF MEDICAL RECORDS

This authorization includes information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, AIDS/HIV, psychiatric/psychological/mental health conditions or treatment which are contained in the records I indicate below.

Please select records:

_____ **2-year Record Summary** (Progress Notes, Radiology, Immunization, Labs, Meds, Consults)

_____ **Physician progress notes** Date(s) of Service:_____

_____ **Lab/test results** Date(s) of Service: _____

_____ **Radiology reports** Date(s) of Service: _____

_____ **Immunization record** Date(s) of Service: _____

_____ **Entire medical record (For Mount Carmel Medical Group, this includes only records we generated.)**

_____ **Other** (list: Ex. Old Records from previous doctor)_____

RECIPIENT OF THE MEDICAL RECORDS

Name_____

Address _____

FOR THE PURPOSE OF:

☐ Continuity of Care ☐ Legal Reasons ☐Other (please specify) _____

☐ Payment / Financial Purposes ☐ Patient Request

I understand that if the recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by the recipient and no longer protected by these regulations.

If I refuse to sign this Authorization Mount Carmel Medical Group will not withhold treatment from me and will not release the information to the recipient specified above.

I understand that I may revoke this authorization at any time. Cancellation of this authorization prior to the limit must be made in writing and sent to the Mount Carmel Medical Group specific physician office. I understand that if I revoke this Authorization, it will not affect any actions that the Mount Carmel Medical Group took before receipt of my revocation letter.

This authorization will expire automatically one year from the date on which it is signed

SIGN HERE_____

Signature of Patient or Personal Representative Date

Printed name of patient's Personal Representative, if applicable _____

Describe Relationship to patient (e.g. minor's parent, guardian) _____

Completed form can be submitted in person or mailed to your Mount Carmel Medical Group Physician Office or emailed to HimMCMG@mchs.com.