MERCY WELLNESS CLINIC
FAMILY PRACTICE

Medical Record Release- For Transfering/Releasing Records

Part 1: Patient Information:

Name:_____ SS#*(not required)*:_____

Date of Birth:_____ Phone #: _____

Part 2: What information are you releasing? (Mark all that apply)

Provider Name/Clinic *(that we are sending records to)*: _____

Phone:_____ Fax:_____

Dates of Treatment being Released (please circle):

Any & All Dates or Only Specific Dates/date range:_____

Records being released (please check all that apply):

- ☐ All health information (all on file)
- ☐ Consultation reports
- ☐ Diagnostic test reports
- ☐ Discharge summary
- ☐ Emergency department records
- ☐ EKGs/cardiology reports
- ☐ History & Physical
- ☐ Laboratory reports
- ☐ Operative reports
- ☐ Past/Present medications
- ☐ Pathology reports
- ☐ Patient allergies
- ☐ Physical/Occupational Therapy reports
- ☐ Progress notes/reports
- ☐ Radiology reports & imaging
- ☐ Other (Specify): _____

Part 3: Purpose of Medical Release: (Please select only one box)

- ☐ Personal use (skip #4)
- ☐ Treatment /continuing medical care
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal purposes
- ☐ Disability determination
- ☐ School
- ☐ Other: _____

Part 4: To be completed only for third-party disclosures.

(If the disclosure is for personal use, skip this section.)

I want the requested medical records to be sent to the third party (for example, an employer or a school) I have indicated below. My completion of this form serves as authorization for Mercy Wellness Clinic to disclose these records to this person or group. I understand that once my information leaves Mercy Wellness Clinic, Mercy Wellness Clinic is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

Name:_____

Mailing Address:_____

Phone:_____Fax: _____

Form Continues onto following Page.

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month ____ Day ____ Year _____

RIGHT TO REVOKE. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION. I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154 © and/or 45 C.F.R § 164.502 (a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: _____ **Date**: _____

Signature of Individual or Individual's Legally Authorized Representative

Printed Name of Legally Authorized Representative (if applicable) _____

If Representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Other _____

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