



Authorization for Disclosure of Protected Health Information (PHI)

Patient Last Name _____ Patient First Name _____ Patient Middle Initial _____ Patient Phone Number _____
Social Security Number _____ Date of Birth _____ Address _____

I, the undersigned, hereby authorize the above named provider or medical facility to disclose in writing to the individual, entity, facility, or company named below my PHI contained in my medical record. I further authorize the above named provider or medical facility to disclose my PHI electronically and/or discuss my PHI verbally with the individual, entity, facility, or company named below. I hereby authorize the disclosed PHI to include (check all that apply):

Items 1 through 7 must be completed.

1. Check off the location(s) you are requesting records from (check all that apply):

- ☐ Mercy Medical Center (Includes Inpatient, Same Day Surgery, Observation, and Emergency Department Visits)
☐ Physician/Provider/Location (fill in name or check off location on page 2): _____

2. Check the type of records to be released (check all that apply):

<input type="checkbox"/> Inpatient	<input type="checkbox"/> Emergency Dept.	<input type="checkbox"/> Other (please specify):
<input type="checkbox"/> Same Day Surgery	<input type="checkbox"/> Outpatient Testing (lab, radiology)	
<input type="checkbox"/> Physician Office Visit	<input type="checkbox"/> Detox Unit	

3. Check specific information to be released (check all that apply):

<input type="checkbox"/> Bills	<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Physician Orders
<input type="checkbox"/> Consultation	<input type="checkbox"/> Implant Record	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Demographic Sheet	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Radiology Films/Imaging
<input type="checkbox"/> EKG/Catheterization Reports	<input type="checkbox"/> Nurse's Notes	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Emergency Room Records	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Any and All Records
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Pathology report	<input type="checkbox"/> Other (please specify):

4. Please specify the date(s) of service below

Date From: MM/DD/YYYY or MM/YYYY	Date to: MM/DD/YYYY or MM/YYYY

5. The information may be disclosed to and used by the following:

Name: Records Deposition Service

Address: P.O. Box 5054 City: Southfield State: MI Zip: 48086-5054

Phone #: (248) 357-3330 Fax #: (248) 357-3337

6. FORMAT: I request that the copy be provided (where possible/available)

- ☐ On paper ☐ Electronically on a password protected CD
☒ Through a web portal, with notice provided to my email account at: requests@recdep.com

7. The purpose of this disclosure or use is for the following reason:

- ☐ Medical ☒ Legal ☐ Disability ☐ Insurance ☐ At the request of the patient ☐ other _____

The PHI provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol and substance abuse, communicable diseases (including HIV/AIDS) and/or genetic marker information. I understand and agree to the following:

- Mercy Health Services does not condition health care treatment I am otherwise entitled to on whether I sign this authorization.
- I understand that the medical records to be accessed may contain medical information pertaining to psychiatric, drug, and/or alcohol, HIV/AIDS diagnosis and treatment.
- This authorization may include records received from other healthcare providers that are part of my Mercy medical record.
- This authorization will expire one (1) year after the date of my signature below unless a shorter time period is stated here _____. (Must be a time period or date, not an event or condition).
- Information used or accessed under this authorization may be re-disclosed by the recipient and no longer protected by federal law but may be protected under Maryland law.
- I am free to revoke this authorization at any time by submitting a written request to the entity/provider disclosing the PHI. Any uses or disclosure of my PHI prior to receipt of the revocation cannot be reversed and will not be covered by the revocation. Please send written request to the Health Information Services Department at Mercy Medical Center.

Signature of Patient (or Legally Appointed Representative) _____

Date _____

Printed name of Legally Appointed Representative (if applicable)
Relationship to Patient _____

Documentation establishing authority of Legally Appointed Representative

(Duly appointed Personal Representative, Health Care Power of Attorney, Advanced Directive, Parent of Minor Child, etc.)



Below is a listing of Mercy Health Services locations. This is not an all-inclusive. Please use this to assist you on filling in the Physician/ Provider/Location. For additional information on Mercy Physicians and Centers, please see our website at <https://mdmercy.com/>.

Check all that apply

<input type="checkbox"/> Baltimore OB/GYN at Mercy	<input type="checkbox"/> Radiology/Imaging at Glen Burnie Personal Physicians
<input type="checkbox"/> Breast Reconstruction and Restoration	<input type="checkbox"/> Radiology/Imaging at Hunt Valley Personal Physicians
<input type="checkbox"/> Business/Employee Health Services	<input type="checkbox"/> Radiology/Imaging at Lutherville Personal Physicians
<input type="checkbox"/> Center for Advanced Fetal Care	<input type="checkbox"/> Radiology/Imaging at Mercy Medical Center
<input type="checkbox"/> Cosmetic Medicine and Surgery	<input type="checkbox"/> Radiology/Imaging at Overlea Personal Physicians
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Dr. Fausto Aquino	<input type="checkbox"/> The Bose Medical Group
<input type="checkbox"/> Dr. Sebastian John	<input type="checkbox"/> The Center for Endocrinology
<input type="checkbox"/> Dr. Sheila Alongi	<input type="checkbox"/> The Center for Interventional Pain Medicine
<input type="checkbox"/> Hoffman & Associates OB/GYN	<input type="checkbox"/> The Center for Minimally Invasive Surgery
<input type="checkbox"/> Maryland Family Care Physicians/Downtown Pediatrics	<input type="checkbox"/> The Center for Restorative Therapies
<input type="checkbox"/> Medical Oncology/Hematology	<input type="checkbox"/> The Gynecologic Oncology Center
<input type="checkbox"/> Mercy Anatomic Pathology	<input type="checkbox"/> The Heart Center
<input type="checkbox"/> Mercy Medical Center	<input type="checkbox"/> The Hoffberger Breast Center
<input type="checkbox"/> Mercy Personal Physicians in Canton	<input type="checkbox"/> The Institute for Cancer Care
<input type="checkbox"/> Mercy Personal Physicians in Columbia	<input type="checkbox"/> The Institute for Digestive Health & Liver Disease
<input type="checkbox"/> Mercy Personal Physicians in Downtown	<input type="checkbox"/> The Institute for Foot and Ankle Reconstruction
<input type="checkbox"/> Mercy Personal Physicians in Glen Burnie	<input type="checkbox"/> The Institute for Gynecologic Care and Oncology
<input type="checkbox"/> Mercy Personal Physicians in Hunt Valley	<input type="checkbox"/> The Lung Center
<input type="checkbox"/> Mercy Personal Physicians in Lutherville	<input type="checkbox"/> The Maryland Bariatric Center
<input type="checkbox"/> Mercy Personal Physicians in Manchester	<input type="checkbox"/> The Maryland Spine Center
<input type="checkbox"/> Mercy Personal Physicians in Overlea	<input type="checkbox"/> The Minimally Invasive Brain and Spine Center
<input type="checkbox"/> Mercy Personal Physicians in Reisterstown	<input type="checkbox"/> The Neurology Center
<input type="checkbox"/> Metropolitan OB/GYN	<input type="checkbox"/> The Shoulder, Elbow, Wrist and Hand Center
<input type="checkbox"/> Orthopedics and Joint Replacement	<input type="checkbox"/> The Urology Specialists of Maryland
<input type="checkbox"/> Plastic and Reconstructive Surgery	<input type="checkbox"/> The Vascular Center
	<input type="checkbox"/> Transitional Care Unit
<input type="checkbox"/> Other (please specify):	
<input type="checkbox"/> Mercy Health Services (includes Mercy Medical Center and all providers/locations)	