Children's Mercy

Authorization for Release of Medical Information by The Children's Mercy Hospital

(Front)

8071-196 MR 12/18

Patient's Full Name and Previous Names Used | Date of Birth (/ /) | MRN (internal use only)

Patient Street Address | City | State | Zip Code

Information To Be Released – Check all that apply

- ☐ Pertinent Health Information (All clinical information for the last 2 years, includes radiology and laboratory reports, does not include images)
- ☐ Outpatient Clinic, Inpatient or ER visit for the following date or date range: _____
- ☐ History & Physical Only
- ☐ Visit List Only
- ☐ Immunization Records Only
- ☐ Other: Please list exact documents and/or date range needed: _____
- ☐ Entire Health Record (Includes all electronic and paper documentation including non-clinical in the patient's record, does not include images, **charges may apply**)
- ☐ Images: (include date range requested)
  - Radiology: _____ Cardiology: _____
  - Neurology: _____ Other: _____
- ☐ Alcohol & Drug Information or HIV Test Results (circle one or both)

Purpose and Method of Release – Check all that apply

- ☐ Doctor appointment on (date): ___/___/___
- ☐ Other ongoing treatment or care
- ☐ Personal Use ☐ Legal Purposes ☐ Other: _____

Release Information By: ☐ Mail Delivery ☐ Fax ☐ Pick Up ☐ CD/DVD ☐ Cloud Images ☐ Encrypted Email (if available/size restrictions apply)

Information Will Be Released To – Please complete all fields

Name and/or Organization: _____

Telephone Number: _____ Fax Number: _____

Email address: _____

Street Address (if different from patient) | City | State | Zip Code

I authorize the use or disclosure of information specified in this authorization regarding the patient named above. I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Health Information Management department of Children's Mercy Hospital. Unless this authorization is revoked, it will expire once the disclosure is complete. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosed. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. I understand I do not need to sign a specific authorization to disclose information for treatment, payment, or health care operations. If I have questions about disclosure of my information, I can contact the Health Information Management department of Children's Mercy Hospital at (816) 234-3455.

Return completed form via email to ROI@cmh.edu or fax to (816) 701-4034

Printed Name of Patient, Parent, or Legal Guardian | Relationship to Patient | ( ) – Telephone Number

Signature of Patient, Parent, or Legal Guardian | Date (/ /)

Street Address (**if different from patient**) | City | State | Zip Code

(See Reverse Side)

Children's Mercy

Authorization for Release of Medical Information by The Children's Mercy Hospital

(Back)

8071-196 MR 12/18

Individuals may request to receive their medical record and other protected health information (PHI), or direct the PHI to a third party, by alternative means, including without encryption. An unencrypted format is at risk for interception or access by an unintended person. Children's Mercy is not responsible for disclosure of PHI sent or stored in an unsecured manner at the individual's request, or for safeguarding the information once delivered.

Please sign below to request records in an unencrypted format. Your signature indicates that you understand and accept the risks of transmitting and storing PHI without encryption.

Printed Name of Patient, Parent, or Legal Guardian	Relationship to Patient	( ) – Telephone Number
Signature of Patient, Parent, or Legal Guardian		/ / Date

Staff Use Only

Released by_____ Date: _____

Return to HIM via email ROI@cmh.edu, fax 816-701-4034 or inter-office mail.