MeritCare

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Patient_____ Chart No._____

Date of Birth:_____ Phone #_____ Social Security #_____-_____-_____

I authorize:

Merit Care Health Systems

To release to: ExamOne
800 NW Chipman Rd. / Suite 5900
POBox 2340
Lee's Summit, MO 64063-1149

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED
(specify dates for each, unless "entire medical record" is selected)

_____ MeritCare treatment from _____(date) to _____(date)
_____ Hospital Admission Summary
_____ Hospital Discharge Summary
_____ Operative Report
_____ Progress Notes
_____ Entire Medical Record for all dates
_____ Billing Information
_____ Other (please specify)_____
_____ I authorize verbal and/or written exchange about my medical information
_____ Lab Reports
_____ X-ray Reports
_____ X-ray Films
_____ Psychiatric Intake
_____ Immunizations
_____ Pathology Report

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:
___Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.

PURPOSE OF THE USE AND DISCLOSURE

_____ Further Treatment (Date of Appointment_____)
_____ Insurance Application
_____ Disability Determination
_____ Vocational Rehabilitation Evaluation
_____ At my request
_____ Other _____
_____ Personal Records
_____ Education
_____ Payment of Insurance Claims
_____ Legal

I authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: _____ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____
Signature of Patient/Guardian/Representative Date

_____
(If not patient, state authority/relationship)