Patient Name: ___________________________

D.O.B.: ___/___/___ MRN: ___________

Children's Mercy

HIPAA Authorization for Release of Health Information (Page 1 of 3)

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This form may be used by a patient or a patient's personal representative to authorize Children's Mercy to either discuss (orally or in writing) or release copies of the patient's Protected Health Information (PHI) with others. For an electronic version of this form contact Health Information Management at (816) 234-3455.

1). What Health Information would you like released

Health Information for the following dates of care

☐ Specific date(s): ____________________ ☐ All dates until expiration or revocation of this Authorization.	☐ This date range: From __________ to __________ Month/Year Month/Year
*If no date specified, the last two years applies.	

Type of Health Information requested

☐ Pertinent Records (the main medical records for **the last two years**, including: history and physical, admission and discharge paperwork, provider progress notes, clinic notes, consultation notes, provider letters, surgery/procedure reports, asthma action plans, radiology/lab/pathology/genetics results or reports, primary documentation from anesthesia, wound care, PT/OT).	☐ All Health Records (entire medical record, including mental health care, alcohol or drug abuse or treatment, HIV/AIDS, and/or other communicable diseases). *For paper or electronic copies: Only the **last two years** will be released unless another time period is specified in the dates of care section above. Includes all records in the designated record set, unless withheld under law. Does not include radiology images.
☐ Outpatient Clinic, ER or Urgent Care Provider Notes	☐ Images or Photos: ☐ Radiology ☐ EKG ☐ EEG ☐ Fetal Monitoring Strips Other (please list):______________________
☐ Discharge Summaries (Inpatient, ER, or Urgent Care)	
☐ Operative (surgery) or Procedure Reports	
☐ Reports (radiology, laboratory, pathology, genetics)	
☐ Physical (Well Child Check Up)	
☐ Home Care Records	
☐ Medication List	
☐ Immunization Record	☐ Itemized Billing Statement
☐ Mental Health Information, check what type: ☐ Evaluation & Treatment Plan(s) ☐ Therapy / Progress Note(s)	☐ Other or Outside Records in Children's Mercy's possession (please specify): ______________________________

***Fees may apply for certain requests, see website for more information:** https://www.childrensmercy.org/about-us/legal/health-information/requesting-copies-of-medical-records/charges-for-complete-medical-records/

2). Health Information can be released to or discussed with

☐ Send records to (or discuss with) the following (please complete all fields):

Individual(s), School or Organization: ______________________________________
Attention: ______________________________________
Street Address: ______________________________________
City: ____________________ State: ______________ Zip code: ____________
Telephone: ____________________ Fax Number (healthcare providers only): ____________

Patient Name: ______________________

D.O.B.: ____/____/_______ MRN: __________

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3). Health Information is needed for the following purpose					
☐ Continuing Care	☐ Personal	☐ Insurance	☐ Legal	☐ School	☐ Other (specify): ______________________

4). If delivery of Health Information is requested, how would you like it delivered	
☐ U.S. Mail delivery (to the individual, school or organization identified in Section 2). Specify the type of copy you would like: ☐ Paper copy ☐ CD	☐ Pick up a copy. Specify the type of copy you would like: ☐ Paper copy ☐ CD *Pick up location: Children's Mercy Hospital Health Information Management Department (HIM) 2401 Gillham Road Kansas City, Missouri 64108
☐ Fax (if sending to another healthcare provider)	☐ By encrypted/ **secure email** to the following email address: ______________________________________ *If available, size restrictions apply.
☐ Cloud images (we send a copy through a secure virtual file-sharing platform, for example we can send the link to your pediatrician's office). Please provide contact information or details on where to send the link:___________________________________	
☐ View in person. Instead of or in addition to obtaining a copy of the PHI, I want to inspect (read) the PHI at Children's Mercy. (Children's Mercy will contact you so that you can select a date, time and location convenient for you during our regular hours of operation).	

By signing this Authorization, I understand that:

I authorize the use/disclosure of any and all of the patient's Protected Health Information (PHI) I have indicated on this form (whether disclosed in writing or orally) up to the expiration or revocation date of this Authorization, unless specifically limited on this form. I understand that this request does not apply to: (1) certain health information that is not held in Children's Mercy's medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA. I understand that: (1) authorizing the disclosure of this PHI is voluntary and I do not need to sign this form to assure treatment, payment or eligibility for services at Children's Mercy; (2) Children's Mercy may deny this request under applicable law; (3) that if PHI is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA; (4) copying fees for certain records may apply; and (5) a photographic copy of this Authorization is as valid as the original. I understand the PHI requested may include information related to the patient's mental health care, alcohol or drug abuse or treatment, HIV/AIDS, and/or other communicable diseases and I authorize the release of such information unless expressly excluded. If I have questions about disclosures of this PHI, I can contact the Health Management Department at Children's Mercy (816) 234-3455.

Expiration:

Unless this Authorization is revoked, it becomes effective on the date of signature and will expire one year from the date signed or on the following date/event/condition: ______________________________.

Revocation:

I understand that I have the right to revoke this Authorization at any time but that such revocation will not apply to information that has already been released in response to this Authorization. To revoke this Authorization, I must provide written notice to the Health Information Management Department at Children's Mercy.

Patient Name: ___________________________

D.O.B.: ____/____/_______ MRN: ___________

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Signature

_______________________________ Printed Name of Patient

_______________________________ Relationship to Patient

_______________________________ Printed Name of Person Signing Form (if not patient)

(____) _____-__________ Telephone Number

____/_____/_________ Date

_______________________________ Signature

If signed by an individual other than a patient or parent, please describe your authority to act on behalf of the patient (*supporting legal documentation granting authority must accompany this Authorization if not previously provided*):

____

Return completed paper form via fax to (816) 701-4034, in person or by mail to:
Children's Mercy Health Information Management
2401 Gillham Road
Kansas City, MO 64108

Staff Use Only

Release by: ___________________________________ Date: ____________________________

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