

# JMJ Medical

8790 Watson Rd Suite 201  
St Louis, MO 63119  
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314-774-0300 Main Office  
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## Authorization for Use and Disclosure of Protected Health Information

**Release to:** Name: JMJ Medical - Rubilinda G. Casino, MD  
Address: 8790 Watson Rd., Suite 201  
City: St. Louis State: MO Zip: 63119  
Phone #: 314-774-0300 866-827-9249

**Release From:** Name: \_\_\_\_\_  
Address \_\_\_\_\_  
City: \_\_\_\_\_ State: MO Zip: \_\_\_\_\_

### Patient or Individual Information:

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Last 4 Digits of Social Security #: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Purpose of Request (Must check one):

- Request of the Patient or individual  Attorney/Legal  Billing/Payment  Treatment or Consultation  
 Other, (specify): \_\_\_\_\_

### I Request My Records be Provided:

- Electronically via MyMercy  Paper (*hard copy*)  Electronically via email\*  Electronically via CD\*

Email address: \_\_\_\_\_

*\*Electronic availability is subject to location and type of records. Billing records and films cannot be provided electronically via email and are available for mail or pick-up only.*

### Information to be Released – Covering the Periods of Health Care (must check one):

- Any and all\*\*  From (date): \_\_\_\_\_ To (date): \_\_\_\_\_

*\*\*includes all records through the date the patient or patient representative signs this authorization.*

### Please check type of information to be released (check all that apply):

- |                                                             |                                                      |                                                |                                                     |
|-------------------------------------------------------------|------------------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input checked="" type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Consultation(s)             | <input type="checkbox"/> Operative Report(s)   | <input type="checkbox"/> Physician Order(s)         |
| <input type="checkbox"/> History / Physical Exams           | <input type="checkbox"/> Diagnostic Testing Reports  | <input type="checkbox"/> Patient Allergies     | <input type="checkbox"/> Progress Note(s)           |
| <input type="checkbox"/> Lab Test Result(s)                 | <input type="checkbox"/> EKG/Cardiology Reports      | <input type="checkbox"/> Pathology Report(s)   | <input type="checkbox"/> Radiology Reports/Image(s) |
| <input type="checkbox"/> Emergency Record(s)                | <input type="checkbox"/> Itemized Billing Statements | <input type="checkbox"/> Patient Medication(s) | <input type="checkbox"/> Treatment Plan(s)          |
| <input type="checkbox"/> Discharge Summary                  | <input type="checkbox"/> Nurses Notes                | <input type="checkbox"/> Clinic Records        | <input type="checkbox"/> Therapy Records            |
| <input type="checkbox"/> Abstract                           | <input type="checkbox"/> Other (specify): _____      |                                                |                                                     |

**NOTE:** This form MAY NOT BE used to release Psychotherapy Notes

### Drug and/or Alcohol Abuse, and/or Psychiatric, and Communicable/Non-Communicable Diseases

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse or treatment, psychiatric care, communicable and/or non communicable diseases including but not limited to hepatitis, gonorrhea, syphilis and/or other sensitive information, I agree to its release. **Check One:**  YES  NO

**HIV/AIDS Records Release**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. **Check One:**  **YES**  **NO**

**Time Limit & Right to Revoke Authorization**

Except to the extent that action has already been taken in reliance on this authorization I can revoke this authorization at any time. Unless revoked, this authorization will expire on the following date or event \_\_\_\_\_ or not to exceed 1 year from date of signature. Indicating "any and all" records to be released will only include all records through the date the patient or patient representative signs this authorization as long as the authorization is not expired or revoked.

**Re-disclosure**

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 or state statute.

**Right to Refuse**

I understand that I do not have to sign this Authorization, and my treatment or payment for services will not be denied if I do not sign.

**Signature of Patient or Patient Representative Who May Request Disclosure**

**I understand there may be a charge for copying my records. State law governs what the Releasing Entity may charge.**

I have read this form, understand and agree to the uses and disclosures of information as described in this Authorization. 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 State statute and/or 45 CFR §164.502(a)(1). I hereby knowingly and voluntarily authorize Mercy Health to use and disclose the protected health information specified above.

\_\_\_\_\_  
*Signature of individual or personal representative* *Date* *Time*

Printed name of individual's personal representative, if applicable: \_\_\_\_\_

Rationale for serving as personal representative to the individual (*e.g., parent, legal guardian*):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Witness Signature (where legally required): \_\_\_\_\_

\_\_\_\_\_  
Verified by (*OFFICE USE ONLY*): \_\_\_\_\_

Identity of Requester Verified (*OFFICE USE ONLY*) via:  
 Photo ID  Matching Signature  Other, specify: \_\_\_\_\_