



Privacy Authorization Form

Date: _____

Member Name: _____ Member Date of Birth: _____ Mercy Healthcare Group ID #: _____

Address: _____ Phone: () _____
Street City, State Zip

Are you the member? Yes No **If "NO", tell Mercy Healthcare Group who you are by checking one of the boxes below. Please give Mercy Healthcare Group copies of any papers that show you have the right to make this request.**

- I am the member's Dad/Mom or guardian.
- I make health care decisions for the member.
- The member has died, and I take care of his or her assets.
- Other (explain) _____

Name of Requestor (if not member): _____ Date of Request: _____

Requestor Address (if not member): _____
Street City, State Zip Telephone Number

I want Mercy Healthcare Group to use or give out records of the member named above because:

- I (the member or person acting for the member) want Mercy Healthcare Group to give out the information described below.
- To help Mercy Healthcare Group coordinate the member's health care
- For workers' compensation claims
- For insurance coverage or payment for care
- Other (tell us): _____

You may / may not (check box that applies) give out any records about:

- AIDS/HIV and other communicable disease (e.g. venereal disease)
- Mental health information (including behavioral health and psychiatric care)
- Alcohol and/or drug abuse treatment
- Genetic testing information

I authorize Mercy Healthcare Group to use or give out records of the member named above to

Enter name of person/entity: _____

Enter address, phone and fax number if known: _____

Tell Mercy Healthcare Group what you want us to give out. You need to provide dates of service, names of providers, etc.

I (the member or person acting for the member) agree to the following:

- I may authorize Mercy Healthcare Group to use or give out member records. When I give an approval, Mercy Healthcare Group will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to Mercy Healthcare Group a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the Mercy Healthcare Group's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell Mercy Healthcare Group when and the reason I want it to end. Use the space below to explain:

- I have read and understand this form.
- I am entitled to receive a copy of this form.

If member - Signature of Member

Date

If member -Print Member Name

If not member - Signature of Legal Representative

Date

Print Name of Legal Representative

Please send this Privacy Authorization Form to:

**Mercy Healthcare Group
4350 E. Cotton Center Blvd., Bldg. D
Phoenix, AZ 85040**

Call Mercy Healthcare Group at 800-780-2300 with questions or comments.

Referral from (specify name of Mercy Healthcare Group employee who sent auth form to requester): _____

Effective Date: 4/03
Revised Date: 02/04