Orthopedic Specialty Hospital at Mercy

Marc W. Hungerford, M.D.
Kamala H. Littleton, M.D
Joseph J. Ciotola, M.D.
Philip R. Neubauer, M.D.
Louis S. Halikman, M.D.
John-Paul Rue, M.D.
Jasmine Toor, M.D.
Gregory Gasbarro, M.D.
Clayton Alexander, M.D.
Mark Slabaugh, M.D.
Gregory Mendez,M.D

301 Saint Paul Place, McAuley Plaza, Lobby Level
Baltimore, MD 21202
(410) 539-2227 Phone
(410) 539-2240 Fax

Dear New Patient,

Please complete the enclosed New Patient paperwork prior to your appointment and bring it with you at the time of your visit. We ask that you arrive at least 30 minutes prior to your scheduled appointment time for registration. Please do not mail or fax this packet to the office.

If your insurance company requires you to have a referral, please make sure you have it with you at the time of your visit. ***We cannot see you without proper authorization from your primary care physician, if it is required.*** Our office is an Orthopedic Specialty office. Please phone your insurance company ahead of time to verify your benefits and requirements needed for your appointment. Providing our Tax ID # 52 – 1495113 to your insurance company may be beneficial when inquiring about your benefits.

If you have not done so already, be sure to ask about signing up for **MyChart.** This is Mercy's Patient Portal that allows you to view your medical information, send questions to your physicians, request prescription refills, view and schedule appointments, and pay your bills online. If you are interested in signing up, ask someone in our office and they will provide you with your activation code.

Thank you.

Narcotic Prescription Policy

The Orthopedics & Joint Replacement Center (OJR) at Mercy is happy to be your orthopedic provider. Our goal is to provide you with pain relief so that you may enjoy functional activity without the use of narcotics or other pain medications. During the normal course of treatments, the use of narcotic pain medication may be required. You may be aware of the growing challenges with narcotic addiction and increased regulations in this area. The purpose of this policy is to inform you of the risks and benefits of narcotic treatment and insure compliance with state and federal laws.

Duration

OJR may supply narcotic pain medication to manage postoperative pain during the first **six weeks** after a total joint replacement or another surgical procedure. It is our expectation that the requirement for narcotic pain medication will decrease over that postoperative period. In the first few weeks you may have more of a need for narcotic pain medication, but it should decrease weekly. The providers and staff will assist you in weaning off of narcotic pain medications.

- Narcotic pain medication can only be prescribed during normal business hours.
  If you choose to pick up a prescription, you will have to do so at the office location in which the provider is practicing on that given day.
- No narcotic pain medication can be prescribed over the phone, after business hours, or on weekends.
- Most narcotic prescriptions require prior authorization from your insurance provider which can take up to 48 hours, plan accordingly.

In rare circumstances patients with other medical conditions such as pain syndromes, chronic back pain, Neuropathic pain etc., may require narcotic pain medication longer than the prescribed postoperative interval. In these circumstances it will be necessary to transfer your care to a specialist who manages chronic pain. If you feel you are unable to wean from narcotic pain medication please inform the staff at OJR. We will work with you to identify a cause, or to arrange referral to a chronic pain management specialist.

Side effects

Side effects associated with opioid therapy include an itching skin rash, nausea, constipation, sleep abnormalities, sweating, and drowsiness. Patients may also have impaired concentration. Making important legal or financial decisions and operating heavy machinery should be avoided. Also, consumption of alcohol with opioid medications should be avoided.

Patient - Physician Agreement Regarding Opioid Prescriptions

I understand these medications have a high potential for misuse and therefore are regulated by local, state and federal government, I agree to the following conditions;

- I will report any signs of addiction promptly
- I will not request or accept controlled substances from any other physician while I am receiving such medication from a physician in OJR.
- I understand that opioid medication is strictly for my own use. The provision of opioid narcotics to other persons endangers that person and violates the law.
- I understand the narcotic prescribing rules outlined above and agree to these restrictions.

Signature _____ Date _____

Orthopedic Specialty Hospital at Mercy
Patient Demographic Sheet

Date: ____/____/____

Last Name: _____ Suffix: _____ First Name: _____ MI: ___

S. S. # ____ - ____ - _____ Birth Date: ____/____/____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)____-____ Cell Phone: (____)____-____ Work Phone (____)____-____

** Email Address: _____

Marital Status: ☐ Single ☐ Widowed ☐ Divorced ☐ Married - Spouse's Name: _____

Race: ☐ African American Alaska Native ☐ White or Caucasian ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic Religion: _____

Preferred language: _____ Interpreter needed: Y / N

Emergency Contact: _____ Phone:(____)____-____ Relationship: _____

Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ Student ☐ Self Employment ☐ Disabled

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Please describe reason for visit: _____

Date of Onset: ____/____/____ How did you hear about us? _____

Referred By: _____ Phone: (____)____-____

Primary Physician: _____ Phone: (____)____-____

Preferred Pharmacy: _____ Phone: (____)____-____

Address: _____ City: _____ State: _____ Zip: _____

Please note: Due to many insurance billing problems we *must* have either a referring doctor's name & phone number or your family physician's name and phone number.

Notice: Referrals/Authorizations are the responsibility of the patient. If your insurance company requires a referral/authorization, you *must* have your referral/authorization at the time of your visit in order to be seen. Failure to do so may result in a rescheduled appointment. *We will not phone your primary care physician to obtain your referral/authorization.*

* Please keep your insurance card(s) and driver's license/photo I.D. out for photocopies *

Height: _____ Weight: _____ Level of pain on a scale of 0-10: _____

Reason for visit to office: _____

Work related accident: Yes No Auto accident? Yes No

Occupation: _____

PLEASE answer the questions on the following pages so that we may better serve you!

PAST ORTHOPEDIC SURGICAL HISTORY---- ---------☐ None

PAST SURGERIES	SIDE/LOCATION			YEAR	NAME OF SURGEON
JOINT REPLACEMENT	RIGHT	LEFT	BOTH		
☐ Total Hip Replacement	☐	☐	☐	_____	_____
☐ Total Knee Replacement	☐	☐	☐	_____	_____
☐ Partial Knee Replacement	☐	☐	☐	_____	_____
☐ Core Decompression	☐	☐	☐	_____	_____
☐ High Tibial Osteotomy	☐	☐	☐	_____	_____
SPINE					
☐ Cervical (neck) Fusion	Levels_____			_____	_____
☐ Cervical Disk	_____			_____	_____
Removal/Decompression/Fusion					
☐ Lumbar (lower back) fusion	Levels_____			_____	_____
☐ Lumbar Disk	_____			_____	_____
Removal/Laminectomy	Levels_____			_____	_____
☐ Thoracic	_____			_____	_____
☐ Kyphoplasty	_____			_____	_____
☐ Tumor/Infection					
SPORTS	RIGHT	LEFT	BOTH		
☐ Knee Arthroscopy	☐	☐	☐	_____	_____
☐ Shoulder Arthroscopy	☐	☐	☐	_____	_____
☐ Rotator Cuff Repair	☐	☐	☐	_____	_____
☐ Total Shoulder Replacement	☐	☐	☐	_____	_____
☐ Other	☐	☐	☐	_____	_____
TRAUMA (list bone/joint and Treatment)	RIGHT	LEFT	BOTH		
_____	☐	☐	☐	_____	_____
_____	☐	☐	☐	_____	_____

OTHER PAST SURGICAL HISTORY---------- ☐ None

BREAST
☐ Lumpectomy *(left or right side)*
☐ Mastectomy *(left or right side)*

CARDIOVASCULAR
☐ Pacemaker
☐ Coronary Artery Bypass
☐ Valve Replacement

GASTROINTESTINAL
☐ Hernia repair
☐ Resection of large bowel
☐ Removal gall bladder

VASCULAR
☐ Abdominal Aortic Aneurysm
☐ Femoral Bypass
☐ Dialysis Shunt
☐ Varicose Vein Stripping

OTHER:
1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____

PAST MEDICAL HISTORY ☐Check if none

BRAIN
☐ TIA
☐ Stroke

ENDOCRINE
☐ Insulin dependent diabetes
☐ Non-insulin dependent diabetes
☐ Hypercholesterolemia
☐ Hypothyroidism
☐ Severe Osteoporosis

HEART
☐ Coronary artery disease
☐ Myocardial infarction (heart attack)
☐ Hypertension/High Blood Pressure

INFECTIOUS
☐ HIV
☐ Hepatitis
☐ Cellulitis
☐ Syphilis
☐ Joint infection

KIDNEY
☐ Chronic Renal Failure

LUNG
☐ Chronic Bronchitis
☐ Pulmonary embolism
☐ Asthma
☐ COPD

MUSCULOSKELETAL
☐ Low Back Pain
☐ Sciatica
☐ Spinal Stenosis
☐ Degenerative disk disease
☐ Juvenile Rheumatoid Arthritis
☐ Lupus
☐ Rheumatoid Arthritis
☐ Psoriasis
☐ Osteoarthritis

CANCER

Type:_____

PSYCHIATRIC
☐ Alcohol Abuse
☐ Major Depression
☐ Anxiety
☐ Bipolar disorder
☐ Schizophrenia

STOMACH &INTESTINE
☐ GERD/Reflux
☐ Gastric Ulcer
☐ Irritable Bowel Syndrome

VASCULAR
☐ DVT (Blood Clot)
☐ Phlebitis
☐ Sickle cell anemia

OTHER:
1._____
2._____
3._____

FAMILY HISTORY -------- ☐ None

Has any member of your family, including parents, grandparents, siblings, ever had the following: check all that apply

Illness:	Family Member:	Illness:	Family Member:
Cancer	_____	Drug/Alcohol Addiction	_____
Hypertension	_____	Glaucoma	_____
Stroke	_____	Bleeding disorders	_____
Mental illness (anxiety/depression)	_____	Other :	_____

SMOKING HISTORY ☐ I have never smoked.

Do you currently smoke? ☐ No ☐ Yes How long have you smoked? _____

I currently smoke: ☐ ¼ pack ☐ ½ pack ☐ ¾ pack ☐ 1 pack ☐ 2 packs per day

I quit smoking: ☐ less than 1 year ago ☐ more than 1 year ago ☐ more than 5 years ago

I formerly smoked: ☐ ¼ pack ☐ ½ pack ☐ ¾ pack ☐ 1 pack ☐ 2 packs per day

What type of tobacco did you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe

ALCOHOL HISTORY

Do you currently drink alcohol? ☐ No ☐ Yes.

If yes, what type of alcoholic beverages do you usually drink?

☐ Beer ☐ Wine ☐ Hard Liquor (such as whiskey, scotch, gin or vodka)

I CURRENTLY DRINK:	I USED TO DRINK:	How many drinks did you drink on a typical day when you are/were drinking?
☐ Less than one time per month	☐ Less than one time per month	☐ 1-2 drinks
☐ 2-4 times per month	☐ 2-4 times per month	☐ 3-4 drinks
☐ 2-3 times a week	☐ 2-3 times a week	☐ 5-6 drinks or more
☐ 4-5 times a week	☐ 4-5 times a week	
☐ 6 or more times a week	☐ 6 or more times a week	

OTHER SUBSTANCES

☐ **I have never used drugs.**

Do you currently use recreational drugs? ☐ Yes ☐ No

Have you used: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other_____

Have you ever developed an addiction to pain medicine? ☐ Yes ☐ No

ACTIVITY HISTORY

Athletics:	Exercises:
☐ Professional	☐ Daily
☐ Amateur	☐ Weekly
☐ Recreational	☐ Rarely
☐ None	☐ Never
Sport_____	Type:_____

MEDICATION INFORMATION -------- ☐ None

High Blood Pressure Medication:	Dose:	When/How often you take it:
☐ Accupril(quinapril)		
☐ Atenolol		
☐ Capoten (captopril)		
☐ Cardizem (Diltiazem)		
☐ Cardura (Doxazosin)		
☐ Cozaar (Losartan)		
☐ Diovan (Valsartan)		
☐ Vasotec (Enalapril)		
☐ Zestril (Lisinopril)		
☐ Lopressor/Toprol(metoprolol)		
☐ Lotesin (Benazepril)		
☐ Norvasc (Amlodipine)		
☐ Procardia (Nifedipine)		

Heart Medication:	Dose:	When/How often you take it:
☐ Lanoxin (digoxin)		
☐ Nitroglycerin		

Blood Thinners:	Dose:	When/how often you take it:
☐ Aspirin		
☐ Coumadin (Warfarin)		
☐ Xarelto		
☐ Plavix		
☐ Pradaxa		

Cholesterol Lowering Medication:	Dose:	When/how often you take it:
☐ Lipitor (Atorvastatin)		
☐ Pravachol (Pravastatin)		
☐ Zocor (Simvastatin)		

Diuretics (Water Pills):	Dose:	When/How often you take it:
☐ Dyazide (HCTZ/Triamterene)		
☐ Pravachol (Pravastatin)		
☐ Zocor (Simvastatin)		

Diabetes (blood sugar) Medications:	Dose:	When/How often you take it:
☐ Glucophage (Metformin)		
☐ Glucotrol (Glipizide)		
☐ Insulin (Humulin)		

Gastrointestinal Medications:	Dose:	When/How often you take it:
☐ Nexium (Esomeprazole)		
☐ Prevacid (Lansoprazole)		
☐ Prilosec (Omeprazole)		
☐ Zantac (Ranitidine)		
☐ Protonix (Pantoprazole)		

MEDICATION INFORMATION---------- ☐ None

Rheumatology:	Dose:	When/How often you take it:
☐ Methotrexate		
☐ Plaquenil		
☐ Prednisone		

NSAIDs:	Dose:	When/How often you take it:
☐ Advil/ Motrin/ Ibuprofen		
☐ Aleve (Naprosyn/naproxen)		
☐ Celebrex		
☐ Mobic		
☐ Diclofenac		

Pain Medication:	Dose:	When/How often you take it:
☐ Percocet (Oxycodone + Tylenol)		
☐ Dilaudid		
☐ Duragesic patch (Fentanyl Patch)		
☐ Endocet/Tylox		
☐ Norco (Hydrocodone +Tylenol)		
☐ Vicodin		
☐ OxyContin		
☐ MS Contin		
☐ Oxycodone		
☐ Tylenol #3		

If you do not see a medication listed, please write it in the "Other Medications" space provided.

Other Medications:	Dose:	When/How often you take it:
☐		
☐		
☐		
☐		
☐		

ALLERGIES --------- ☐ None

MEDICINE	REACTION	GENERAL	REACTION
☐ Aspirin		☐ Latex	
☐ Erythromycin		☐ Adhesive	
☐ NSAIDS		☐ Nickel	
☐ Penicillin		☐ Other	
☐ Sulfa			

REVIEW OF SYSTEMS: *Please mark the symptoms you are currently experiencing:*

Constitution
- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Excessive/Unusual Sweating
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected wt. change

HENT
- ☐ Congestion
- ☐ Dental Problem
- ☐ Drooling
- ☐ Eye Discharge
- ☐ Eye Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Runny Nose
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ Trouble Swallowing
- ☐ Voice Change

EYES
- ☐ Eye discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Extreme Sensitivity to Light
- ☐ Visual disturbance

Respiratory
- ☐ Apnea
- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of breath
- ☐ Stridor
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Palpitations

GI
- ☐ Abdomen distention
- ☐ Abdomen pain
- ☐ Anal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Excessive Urination

GU
- ☐ Difficulty urinating
- ☐ Dysuria
- ☐ Enuresis
- ☐ Flank pain
- ☐ Frequency
- ☐ Genital sore
- ☐ Blood in Urine
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain
- ☐ Urgency
- ☐ Urine decreased

Musculoskeletal
- ☐ Joint Pain
- ☐ Back pain
- ☐ Gait problems
- ☐ Joint swelling
- ☐ Muscle Pain
- ☐ Neck pain
- ☐ Neck stiffness

Skin
- ☐ Color change
- ☐ Pallor
- ☐ Rash
- ☐ Wound

Allergy/immune
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Immunocompromised

Neurological
- ☐ Dizziness
- ☐ Facial asymmetry
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Syncope
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Adenopathy
- ☐ Bruises/bleeds easily

Psychiatric
- ☐ Agitation
- ☐ Behavior problem
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Dysphoric mood
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous/anxious
- ☐ Self-Injury
- ☐ Sleep disturbance
- ☐ Suicidal ideas

CONSENT & ASSIGNMENT – *Please Read Before Signing*

MEDICARE:
I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

BLUE SHIELD OF MARYLAND:
I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc payment and, if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process this claim. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

LEGAL ASSIGNMENT (Applicable to Physician Services):
The undersigned expressly agrees that if, upon default, this matter is referred for collection, the undersigned agrees to pay an attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral which percentage and the amount resulting there from are considered reasonable by the undersigned, and all court costs incurred therewith, as well as private process server fees.

WORKMAN'S COMPENSATION:
I understand that if for any reason my worker's compensation carrier denies payment for services that were rendered to myself, I will be financially responsible.

AUTOMOBILE INSURANCE:
I understand that once my PIP has been exhausted, I will be financially responsible for any charges incurred in the event our office does not accept my health insurance and services that are not authorized by my health insurance.

INSURANCE ASSIGNMENT:
I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.

MANAGED CARE:
I understand that, without an authorization/referral from my insurance company, I will be financially responsible for charges I incur.

CONSENT TO CONTACT VIA TELEPHONE:
I authorize Mercy Health Services* or its collection agency to contact me regarding my insurance, account billing, or its collection activity. Mercy Health Services or its collection agency may contact you by telephone at any phone number associated with your account, including wireless numbers, which could result in charges to you. Methods of contact may also include pre-recorded voice messages and/or use of an automatic dialing service.
I understand that my consent will remain in effect until I revoke it, but that I may withdraw consent at any time, or change my instruction regarding how I may be contacted, by notifying Mercy Health Services' Billing Office at 410-332-9674.

GUARANTEE:
As an inducement for the providing of services to the patient, the undersigned absolutely and unconditionally guarantees to SPPS and its successors and assigns, the full and complete payment due by the patient, as and when the same becomes due.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN:

SIGNATURE: _____ DATE: ___/____/____
(Sign Here)

SIGNATURE: _____ DATE: ___/____/____
I authorize a copy of this authorization to be used in place of the original.

For billing purposes our center is designated as an Outpatient Hospital Facility. You will receive two bills for your appointment(s). You will receive a bill from our physicians in addition to a bill from the hospital. Both bills represent charges incurred during your visit in our center.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I received Mercy Health Services' Notice of Privacy Practices. I understand this notice describes how medical information about me may be used and disclosed, my rights regarding the use and disclosure of this information, and how I can obtain access to this information

PATIENT SIGNATURE: _____ DATE: ____/____/____

Mercy
HEALTH SERVICES

Mercy
HEALTH SERVICES

BILLING NOTICE TO OUR PATIENTS

The Center for Orthopedics & Joint Replacement is an outpatient department of Mercy Medical Center. Accordingly, you will notice separate charges for your appointments in the Center on your billing statement. You will receive a physician services charge from the physician group and an outpatient clinic charge from Mercy. Together, the two charges represent fees incurred during your visit to the Center and we provide this notice to help avoid confusion when you receive two separate bills.

Depending on your insurance coverage, you may be responsible for some or all of both charges. All charges are billed to the patient's insurance company to determine the amount of patient responsibility. If in doubt, please contact your insurance carrier to determine the co-pay, deductible and/or coinsurance amounts.

Thank you.

I have read and understand this billing notice:

Patient Name – Printed	Date of Birth
Patient Signature	Date of Signature

EXIBIT C

Notice of Physician's Financial Interest

I, _____ (patient name) am aware that the following physicians (or an immediate family member) have financial ownership interest in the diagnostic treatment facility or in the treatment(s), goods, or services names below. I acknowledge that I have the right to obtain these services or a comparable product from another provider of my choosing. Upon request, my doctor will provide me with a list of other providers or discuss any alternative treatment options with me.

Dr. Hungerford: SurgCenter of Towson, New ERA Orthopedic

Dr. Neubauer: SurgCenter of Towson

Dr. Littleton: SurgCenter of Towson

Dr. Rue: SurgCenter of Towson, Maryland Specialty Surgery Center

Dr. Gasbarro: SurgCenter of Towson

Dr. Slabaugh: SurgCenter of Towson

I have read this Notice of Physician's Financial Interest and acknowledge the above listed physician's (or the physician's immediate family member) financial interest in the facility, treatment, goods or services listed above.

_____

Signature of Patient or Guardian

_____

Relationship to Patient

_____

Date

Permission to Discuss Health Information with Family and Friends

This form allows you to identify those family members, friends, or other persons involved in your care that you would like to give Mercy permission to talk with about your medical care. You may also identify any person(s) with whom Mercy should not share your health information.

Patient Name: _____

I give permission to allow Mercy Health Services (Mercy) to verbally discuss the following health information about me:

- ☐ Scheduling/appointment information
- ☐ Medical information, including symptoms, diagnoses, medications, and treatment plan.
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ All of the above
- ☐ Other: _____

Mercy has my permission to discuss the above information with:

Name	Cell Phone	Work Phone	Relationship

I understand that:

- I do not have to sign this form, and I should only sign it if I want Mercy to be able to discuss my health information with someone.
- In certain circumstances, Mercy may speak to other individuals who are involved in my care, if permitted by law, that may not be identified on this form.
- I have the right to revoke my permission at any time, or update this form at any time by contacting: Compliance Hotline 410-576-5297; Toll free 1-855-576-5297.
- This form does not authorize releasing copies of my medical records. If you would like Mercy to share copies of your medical records with someone, you will need to fill out an Authorization form, which is available by calling your physician's practice.

Mercy is permitted to share certain health information with family, friends, and other persons (i.e., caretakers) if they are involved in your healthcare. If there are any family members or other persons with whom Mercy should not share any of your health information, please identify those persons below:

_____

Mercy will document a restriction on your medical record for the person(s) listed above, and unless otherwise required by law, will not share information these persons.

_____ _____

Signature of Patient/Authorized Representative Date

If other than patient, state authority to sign: _____

OFFICE NOTE: Patients may fill out and sign this form or Mercy Staff may verbally discuss the information in this form with the patient and document the patient's wishes in the medical record.