An Affiliate of UnityPoint Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.

PATIENT: Name: ______________________ Medical Record Number: ______________

IDENTIFICATION: Date of Birth: ______________________
Parents/Previous name(s): ______________________

PROVIDER: Name: ______________________
(Who is releasing the information sent) Address: ______________________
Phone: ______________________ Fax: ______________________

INFORMATION:

- ☐ Complete Records ______________
- ☐ Immunization Record ______________
- ☐ Lab Data: Date ______________
- ☐ X-ray Data: Date ______________
- ☐ EKG: Date ______________
- ☐ D/C Summary: Date ______________
- ☐ H&P: Date ______________
- ☐ Other ______________

PURPOSE:

- ☐ Transferring Medical Care
- ☐ Moving
- ☐ Insurance Coverage
- ☐ Other ______________

INFORMATION SENT TO: Name: ______________________ Phone: ______________________
Address: ______________________ Fax: ______________________
____

Specific Authorization for Release of Information Protected by State or Federal Law
I understand that this will include health information relating to (check, sign & date if applicable):

- ❑ **HIV (human Immunodeficiency Virus) infection**
- ❑ **Mental Health**
- ❑ **Treatment for alcohol and/or drug abuse**
- ❑ **Genetic Testing**
- ❑ **Sexually transmitted diseases**

Signature: ______________________ **Date:** ______________________

Guthrie County Hospital/Clinics will not condition treatment on your signing this authorization, unless: (1) you are receiving research-related treatment; or (2) the only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Guthrie County Hospital/Clinics. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Guthrie County Hospital/Clinics. The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Guthrie County Hospital/Clinics Notice of Privacy Practices.

______________________ ______________________
Signature of Patient or Legal Representative **Date**

______________________ ______________________
Relationship to Patient, if not signed by Patient **Witness**

PROHIBITION OF REDISCLOSURE

Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42.C.F.R. Part 2) and state requirements (Iowa Code ch.228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. I understand all other information used and/or disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

(A copy of this signed form will be provided to the patient upon request)

1.MR.15 HIS Revised/ 09/05 – Revised 03/2007; 07/07; 9/2014