AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

MR#

NAME_____ EMAIL ADDRESS: _____

PHONE #: _____ DATE OF BIRTH:_____ SOCIAL SEC #: xxx-xx-_____

ADDRESS: _____

I **hereby authorize written RELEASE of my healthcare information as indicated:**	
Release Information **FROM**	Release Information **TO**
Name:	Name:
Address:	Address:
City, State ZIP:	City, State ZIP:
Phone:	Phone:
Fax:	Fax:
Please send my records by: ☐ Mail ☐ Fax ☐ Patient Pick-Up	

INFORMATION REQUESTED: (check all that apply)		**REASON FOR RELEASE:**	
☐ Immunization Records	☐ Clinic Notes	☐ Treatment/Continued Care	☐ Personal
☐ Lab Reports	☐ ER/Hospital Notes	☐ Legal/Attorney	☐ Transfer of Care
☐ X-ray Reports Only	☐ X-Ray Images	☐ Insurance Purposes	
☐ Other (Specify):		☐ Other (Specify):	
☐ My **complete medical records** from/to the following date(s): **OR** about the following **condition**(s):			

I authorize, with my initials, the release of the following types of records: (please initial even if you do NOT have such records)

Initial _____ **Mental Health records** Initial _____ **HIV/AIDS information** Initial _____ **Substance Abuse records**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient. See also Chapter 228 and Chapter 141A of the Iowa Code and other applicable laws. **If mental health information is being disclosed, I acknowledge receipt of a copy of this Authorization.**

ALTERNATIVE CONFIDENTIAL COMMUNICATIONS: (Applies to General and Special Release)

Initial _____I authorize transmission of my medical information by FAX for treatment purposes

Initial _____ I authorize reciprocal release of the above information between these Providers/Facilities

Initial _____ I authorize release of information from other facilities that are part of my record

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Health Information Dept. I understand that any release, which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand as a patient I have the right to access my records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand that Mitchell County Regional Health Center Clinics/Hospitals may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services. This authorization will expire on the following date, event, or condition_____. **If I fail to specify, this authorization will expire in twelve (12) months.** A photocopy of this signed authorization shall be as effective as the original.

_____ _____

Patient/Representative Signature **Date**

_____ _____

Representative's Relationship to the Patient **Witness**