Authorization to Disclose Protected Health Information

Regional Medical Center / Regional Family Health
Health Information Services, Release of Information
PO Box 359 Manchester, IA 52057 Phone: (563) 927-7433

Please PRINT (except signature) and provide complete information in each section

Patient Name: _____ **Date of Birth:** _____
Last First MI

Patient Address: _____ **Phone:** _____

Information From: (Provide name and address of institution)	**Information To:** (Provide name and address of person/institution)

I give permission to the provider(s) listed above to give the following information from my health record to the individual(s) / institution(s) listed above for the purpose of:

❑ Medical Care ❑ Legal Use ❑ Transferring Care ❑ Other (specify): _____

Please check the information to be shared via paper, verbal or electronic exchange. Include dates where indicated:

❑ Most recent (choose one) ❑ History & Physical ❑ Discharge Summary ❑ Emergency Department Note
❑ Laboratory (specify type or date) _____
❑ Test results (i.e. EKG, PFT, etc) (specify type or date) _____
❑ Consultation report(s) (specify type or date) _____
❑ Xray and imaging reports (specify type or date) _____
❑ Xray and imaging films (specify type or date) _____
❑ Clinic records _____
❑ Permission to share _____
❑ Billing information (specify date) _____
❑ Other (please specify) _____

Note: If the information includes mental health treatment, substance abuse treatment, HIV-related information, or genetic tests/information, it will not be released unless you agree to the release on the reverse side of this form.

Affirmation of Release:

I give Regional Medical Center/Regional Family Health or the provider(s) listed above permission to release the information I have selected on this form to the individual(s) or Institutions(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date signed and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment, or my eligibility for benefits. The revocation will take effect on the day it is received in writing in the Health Information Services Department. Copies of my records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulation or a business associate with these entities, the information described above may be redisclosed and no longer protected by the regulations.

_____ _____
Signature of Patient or Legal Representative Date Signed

_____ _____
If signed by Legal Representative, Relationship to Patient Date Signed

Information disclosed by: _____

❑ A copy of the signed Authorization to Disclose Protected Health Information has been provided to the patient / legal representative.

Regional Medical Center MANCHESTER, IOWA (563) 927-3612 Regional Family Health A service of Regional Medical Center www.regmedctr.org

Authorization to Disclose Protected Health Information

Specific Authorization for Release of Information Protected by State or Federal Law

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, HIV-related information, and/or genetic tests/information. I specifically authorize the release of information relating to: (you must check appropriate boxes)

- ❑ Acquired immunodeficiency syndrome (AIDS) / human immunodeficiency virus (HIV) infection, diagnosis and test results
- ❑ Mental health treatment
- ❑ Substance abuse (Drug, alcohol or tobacco use)
- ❑ Genetic tests / information - refers to genetic testing to screen for possible future health issues; does not refer to testing to diagnose or treat current health conditions.

Signature of Patient or Legal Representative _____ Date Signed _____

If signed by Legal Representative, Relationship to Patient _____ Date Signed _____

You must sign in order for above information to be released.

Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, mental health, or HIV-related information must be accompanied by the following written statement:

> 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.