AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

PATIENT NAME_____ BIRTH DATE_____

I, the undersigned, hereby authorize_____
(Name of Provider)

Information to be disclosed:

- ❑ Complete Health Records
- ❑ History & Physical Exam
- ❑ Consultation Report
- ❑ X-Ray Report
- ❑ Discharge Summary
- ❑ Progress Notes
- ❑ Laboratory Notes
- ❑ Photos / Videotapes

DISCLOSE INFORMATION TO: _____
(Person or Organization)

Address: _____

_____

YES, I would like to have my information sent via Secure Electronic Email

Email Address: _____

PURPOSE OF DISCLOSURE: ❑ Transferring Care ❑ Moving ❑ Insurance Coverage
❑ Personal Access to Protected Health Information
❑ Other_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of information relating to: (PLEASE CIRCLE YES OR NO)

YES / NO Substance Abuse *(Alcohol/Drug Information)*
YES / NO Mental Health Information
YES / NO HIV Related Information *(AIDS Related Testing)*
YES / NO Information Protected by State and Federal Laws as Related to a Minor

_____ _____
PATIENT/GUARDIAN SIGNATURE *DATE*

** In order for the above information to be released, you must sign here **AND** below.*

This authorization will expire on the following date, event or condition: _____ unless otherwise revoked, effective for no longer than 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 Family Health Care of Siouxland, Medical Record Department. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under the appropriate conditions established by Family Health Care of Siouxland, Medical Record Department.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein.

**** For redisclosure information, please see back of the form.***

Patient/Guardian or Legal Representative_____

Relationship to Patient _____

Signature of Witness _____

DATE:_____

II. REDISCLOSURE

Iowa and/or Federal law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, as indicated below.

I further understand that the Recipient, WITHOUT FURTHER AUTHORIZATION, may redisclose said information to:

❑ (A) Parties and their legal counsel, insurers, experts, potential experts, anyone against whom claim is or has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any of said persons:

OR INSTEAD

❑ (B) (CHECK ONLY IF APPLICABLE) ONLY to the following:

_____

_____

I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE.

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

> This information has been disclosed to you from the 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.
>
> See also Chapter 228 of the Iowa Code and Section 141.23 (3) of the Iowa Code and other applicable laws.