AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Staff Use Only

☐ HIM Release Fulfilled	☐ Request Sent to External Organization
Medical Record Number	Date Fulfilled *(mm-dd-yyyy)*

Instructions: please print clearly; each section needs to be completed for the authorization form to be valid.

1. Patient Information

Patient Name *(First, Middle, Last) (include any previous or maiden names)*	Birth Date *(mm-dd-yyyy)*	☐ Check this box if patient is deceased.
Patient Address *(Street, City, State, ZIP code)*	Daytime Phone	

2. Reason for Request

Check appropriate box or write in other purpose.

- ❑ Consult/Treatment
- ❑ Transferring Care
- ❑ Disability
- ❑ Personal
- ❑ Insurance
- ❑ Workers' Compensation
- ❑ Legal
- ❑ Other ____

3. Release Information FROM

What organization should share your information? Check at least one box.

☐ **Iowa Specialty Hospitals & Clinics** – ALL locations

OR *choose from the specific locations:*

❑ Ames	❑ Belmond	❑ Boone	❑ Clarion	❑ Clear Lake
❑ Des Moines	❑ Fort Dodge	❑ Garner	❑ Hampton	❑ Humboldt
❑ Mason City	❑ Rockwell	❑ Webster City		

OR *specify organization, department, or individual provider:*

☐ **Other** Organization/Department/Provider Name ____

Street ____

City ______________________ State ______________ ZIP Code ______________

Phone ______________________ Fax ______________________

4. Send Information TO

Who do you want to send your information to? Check one box.

☐ **Other** - specify organization, department, or individual:

Name ________________________________ Attn ______________________

Street ____

City ______________________ State ______________ ZIP Code ______________

Phone ______________________ Fax ______________________

Email ____

OR *specify ISH clinic, department, or individual provider:*

☐ **Iowa Specialty Hospitals and Clinics**

Clinic ______________________ Department or Provider ______________________

Fax ______________________ Attn ______________________

Iowa Specialty Hospitals & Clinics

Health Information Management Department
Phone: 515-532-9349 / Fax: 319-343-1108

Belmond Campus
403 1st St SE
Belmond, IA 50421

Clarion Campus
1316 S Main St
Clarion, IA 50525

5. Delivery of Information

How do you want your information to be sent?

- ❑ Fax
- ❑ US Mail
- ❑ Email
- ❑ Verbal Only

Date Information Needed by ____________________________________

- ❑ MyChart Document Center
- ❑ Onsite Pick-Up, specify location ________________________________
- ❑ Other, please specify____

6. Information to Be Shared

What information do you want to be sent? Check all that apply. (Note: sensitive records will not be shared unless checked in Section 7 below.)

ALL Medical Records for: ☐ Clinic Visits ☐ Hospital Visits (Inpatient Admissions and Outpatient Services)

***OR** specify only certain types of information:*

- ❑ History & Physical Notes
- ❑ Clinic Visit Notes
- ❑ Lab/Pathology Results
- ❑ Sleep Studies
- ❑ Allergy List
- ❑ Operative Notes
- ❑ Emergency Dept Notes
- ❑ Radiology Results
- ❑ Vaccine Records
- ❑ Medication List
- ❑ Inpatient Progress Notes
- ❑ Pregnancy Records
- ❑ Radiology Imaging (email required)
- ❑ Billing Statements
- ❑ Discharge Notes
- ❑ Behavioral Health Records (including mental health & substance abuse)
- ❑ Other ___________________

Dates of Care *(past 2 years will be sent unless otherwise specified below)*

From ____ *(mm-dd-yyyy)* To ____ *(mm-dd-yyyy)*

7. Authorization

I am asking to share my protected health information described above that is kept by Iowa Specialty Hospitals & Clinics. I understand that this information may include details about sexually transmitted diseases, AIDS, HIV, genetic testing, mental or behavioral health, and treatment for alcohol or drug use*.

*I understand that substance abuse records are protected by federal laws, and these laws do not allow me to reshare these records without written permission from the patient unless otherwise allowed; 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

I authorize the release of these record types: ☐ **Substance Abuse** ☐ **Mental Health** ☐ **AIDS/HIV** ☐ **Genetic Testing**

- I understand that Iowa Specialty Hospitals & Clinics will not refuse treatment if I choose not to sign this form.
- I understand that once my health information is shared as requested on this form, it may no longer be protected by federal and state privacy laws. The person who receives it may share it again.
- I understand that emails are not always secure. There is a chance my information could be seen by someone other than the person it was sent to. If I choose to get my health information by email, I accept this risk.
- I understand there may be a fee to get a copy of my health information. The fee will follow the law, and I agree to pay it.
- I understand I can ask for a copy of this form at any time.
- I understand that my request will be completed within 30 days after this form is received, unless I am told otherwise.

Canceling Authorization
I understand I can cancel this authorization at any time by sending a written notice to the Health Information Management Department at Iowa Specialty Hospitals & Clinics. This authorization allows my protected health information to be shared after the signature date for the time period specified in section 6. It will expire one year after the date I sign it, or on the date written here_________/_________/_______________, unless I cancel it earlier. I also understand that there are some exceptions to this rule, as explained in federal law (45 CFR Part 164.512).

SIGNATURE (required)	**DATE (required)** *(mm-dd-yyyy)*

Printed Name of Person Signing *(First, Middle, Last)*

Relationship to Patient, if not patient *(legal documentation may be required)*

❑ Parent ❑ Foster Parent ❑ Legal Guardian ❑ Health Care Power of Attorney ❑ Executor ❑ Other _______________

Note: A patient age 18 or older must give permission to release their own protected health information unless they are unable to do so or have passed away. By signing for a minor, you are confirming your parental rights have not been taken away by a court. In some cases, a minor may still need to give their own permission.