LUCAS COUNTY HEALTH CENTER

An Affiliate of UnityPoint Health

CHARITON CLINIC

Request for Release of Protected Health Information
(From Another Facility to Lucas County Health Center)

Name of Patient: _____ **Maiden/Previous Name:** _____
Date of Birth: _____ **Phone #:** _____
Street Address: _____ **City, State, Zip:** _____

I, the undersigned, do authorize and request _____ **(Name of Facility)** _____ **Address, City, State, Zip),** _____ **(Phone),** _____ **(Fax) to release to Lucas County Health Center the following health care information:**

☐ Complete Medical Record ☐ History and Physical ☐ Laboratory Reports
☐ Radiology Reports ☐ Office Notes ☐ OB Records
☐ Immunization Records ☐ Records from specific date (please specify) _____
☐ Other (please specify): _____

Reason for Disclosure:
I would like this information released for the following purpose(s):
☐ Continued care by another provider ☐ Referral to another provider ☐ Moving ☐ Other: _____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse. By signing this form, I authorize release of the following:
☐ Substance abuse (including alcohol/drug abuse) ☐ HIV-related information (including AIDS related testing)
☐ Psychotherapy notes/Mental Health

I have read and understand the following:
- This authorization expires one year after I sign it or sooner (specify here: _____.) This time period noted here may exceed one year only in certain situations specified by law. I may revoke this authorization at any time by notifying the facility in writing that I have authorized to release my records and this authorization will cease to be effective on the date notified. This will not apply to records that have already been released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- To be valid, this authorization must be filled out completely and signed. A copy is valid only if it has not been altered.

Signature of Patient/Parent/Legal Guardian/Authorized Representative: _____
Relationship to Patient: _____ Date: _____
Witness: _____ Date: _____

<u>Please send information to:</u>
LCHC Chariton Clinic
Attn: Medical Records
1200 North 7th Street
Chariton, IA 50049
Phone: (641) 774-8103 • Fax: (641) 774-3388