LUCAS COUNTY HEALTH CENTER

An Affiliate of UnityPoint Health

CHARITON CLINIC

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

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

I, the undersigned, do authorize and request:
☐ LCHC Chariton Clinic (1200 North 7th Street, Chariton, Iowa 50049, (641) 774-8103)

Release Information to the following:
☐ Mail to following address (include name): _____
☐ Fax to the following name and number(s): _____
☐ The following representative will pick up at LCHC's Chariton Clinic: _____

Information to be released:
☐ Complete Medical Record ☐ History and Physical ☐ Laboratory Reports
☐ Radiology Reports ☐ Office Notes ☐ OB Records
☐ Immunization Records ☐ Other (please specify): _____

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

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

If leaving our clinic - please provide a reason(s):
☐ Moving ☐ Convenience of hours
☐ Dissatisfaction ☐ Convenience of location
☐ Insurance coverage ☐ Other: _____

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.
- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. Once the records are released, LCHC cannot prevent them from being released to a third party.
- We do not release secondary information from other physicians or facilities.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.
- To be valid, this authorization must be filled out completely and signed. A copy is valid only if it has not been altered.
- If I do not complete and sign this authorization, my healthcare and payment for my healthcare will not be affected, and will not jeopardize my right to obtain present or future treatment, except where disclosure of the information is required for the treatment.

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

**If other than the patient's or parent's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. appointed guardian, durable power of attorney for healthcare.)*