LUCAS COUNTY HEALTH CENTER
An Affiliate of UnityPoint Health

Authorization for Release of Patient Information

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City, State, Zip: _____

Phone Number: _____ Maiden/Previous Names: _____

GENERAL RELEASE:

I authorize _____ (provider/facility) to release my information to:

Name	**Phone**
Address	**Fax**

DESCRIPTION OF RECORDS TO BE RELEASED: Date(s) of Service(s) _____

☐ Discharge Summary
☐ History and Physical
☐ Operative Report
☐ Other _____
☐ Clinic notes
☐ Immunization Records
☐ Lab Results
☐ X-ray results
☐ EKG
☐ Medication List

PURPOSE OF RELEASE: ☐ Continuing Care ☐ Patient Request ☐ Legal ☐ Other_____

SPECIAL RELEASE: The following information requires special consent by law. Even if you indicate **entire medical record**, you must specifically request the following information in order for it to be released (check as appropriate).

☐ Yes ☐ No Alcohol/Substance Abuse Records _____ (initials)
☐ Yes ☐ No HIV/Aids Information _____ (initials)
☐ Yes ☐ No Mental Health Evaluation/Treatment _____ (initials)

EXPIRATION: This authorization is good until: ☐ ____/____/_____ or ☐ _____
(specify date) (specify event)

*If not otherwise specified, this authorization will expire within twelve months of the date of the signature.

I understand that I may revoke this authorization in writing at any time by sending a written request to Lucas County Health Center at 1200 North Seventh Street, Chariton, Iowa 50049, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that I may inspect and/or copy the information disclosed. I understand that information disclosed pursuant to this authorization potentially could be subject to re-disclosure by the recipient, and if re-disclosed the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this authorization form. I also acknowledge receipt of a copy of this Authorization.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____
Printed name and authority of patient's legal representative (i.e. Parent/Guardian/Power of Attorney)

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE PATIENT OR PATIENT'S REPRESENTATIVE

NOTICE:
This information has been disclosed 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.

For Business Use Only: Medical Record No: _____ Request Completed by: _____ Date: _____