Authorization for Release of Patient Information

LUCAS COUNTY HEALTH CENTER
An Affiliate of UnityPoint Health

Health Information Management Department

Phone #: 641-774-3229 Fax #: 641-774-8087

IMPORTANT! Make sure all blanks are filled in. Failure to do so could prevent or delay processing.

PATIENT INFORMATION	Patient Name _____ Maiden/Previous Names_____ Address_____ City_____State_____Zip_____ Date of Birth_____Social Security #_____ Phone Number_____ Cell Number_____
PROVIDER/FACILITY (I authorize this provider/facility to release my information)	Provider Name_____ Address_____ City_____State_____Zip_____ Phone Number_____ Fax Number_____
RELEASE TO (Where do you want the information sent)	Name_____ Address_____ City_____State_____Zip_____ Phone Number_____ Fax Number_____
INFORMATION/ RECORDS TO BE RELEASED	Service Dates_____ ____ Clinic Notes ____ Immunization Records ____ History & Physical ____ Lab/X-Ray Results ____ Operative Report ____ Discharge Summary ____ EKG ____ Medication List ____ Other _____
PURPOSE OF RELEASE	____ Continuing Care ____ Patient Request ____ SSA/Disability ____ Legal ____ Other _____
REQUESTED FORMAT	____ Paper ____ CD (Password Protected)
HOW WOULD YOU LIKE TO RECEIVE YOUR RECORDS	____ Mail ____ Fax ____ Patient Pickup
SPECIAL RELEASE SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW	**I authorize the release of the information listed below, which requires specific consent under federal law. Check all that apply** ____ Alcohol/Substance Abuse ____ HIV/AIDS Information ____ Mental Health Evaluation/Treatment Signature of Patient or Authorized Representative_____ Relationship (If not patient) _____

This authorization is effective for _____ months but no longer than 1 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 the Health Information Management Department at Lucas County Health Center. 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 coy 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. I understand I am entitled to receive a copy of this completed authorization form.

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.

By signing below, I acknowledge that I have read and I understand this authorization form.

_____

Signature of Patient or Patient's Authorized Representative

_____

Printed Name Relationship to Patient

_____

Date

For Internal Use Only:

Medical Record # _____ Request Completed By _____ Date _____