AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

MAKE SURE ALL BLANKS ARE FILLED IN. FAILURE TO DO SO COULD PREVENT OR DELAY PROCESSING

PATIENT INFORMATION

NAME (LEGAL, MAIDEN, OTHER) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ DOB _____

RELEASE INFORMATION FROM

DALLAS COUNTY HOSPITAL
610 10TH STREET
PERRY IA 50220

RELEASE INFORMATION TO

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

INFORMATION REQUESTED

SERVICE DATES _____

☐ ALL RECORDS ☐ DISCHARGE SUMMARY ☐ EMERGENCY ROOM REPORT
☐ LABORATORY REPORT ☐ RADIOLOGY REPORT ☐ EKG | CARDIOLOGY
☐ HISTORY AND PHYSICAL ☐ OTHER _____

FORMAT

☐ PRINTED RECORDS TO PICK UP ON (DATE) _____
☐ PRINTED RECORDS TO MAIL TO _____
☐ FAX RECORDS TO (FAX NUMBER) _____

PURPOSE

☐ CONTINUED CARE ☐ TRANSFERRING CARE ☐ LEGAL
☐ INSURANCE ☐ PERSONAL ☐ OTHER _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

PLEASE CHECK EITHER YES OR NO IN EACH APPLICABLE LINE TO RELEASE THE SPECIFIC INFORMATION

Substance Use/Abuse ☐ Yes ☐ No
Mental Health ☐ Yes ☐ No
STD/HIV-Related Information ☐ Yes ☐ No
Genetic Information ☐ Yes ☐ No

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ DATE _____

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT _____

REVOCATION
I UNDERSTAND I MAY RECOKE THIS AUTHORIZATION AT NY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE UPON IT, BY GIVING A WRITTEN NOTICE.

INSPECTION
I UNDERSTAND I HAVE THE RIGHT TO INSPECT THE INFORMATION TO BE DISCLOSED UPON THE PROPER NOTIFICATION TO AND UNDER APPROPRIATE CONDITIONS ESTABLISHED BY DALLAS COUNTY HOSPITAL.

THERE MAY BE A FEE ASSOACIATED WITH YOUR REQUEST
THE STATEMENT MADE IN THIS AUTHORIZATION ARE BINDING, CONTROLLING, AND I UNDERSTAND THAT THEY TAKE PRECEDENCE OVER STATEMENTS IN THE ORGANIZATION NOTICE OF PRIVACY PRACTICES.

THIS AUTHORIZATION IS EFFECTIVE FOR _____ MONTHS, BUT NO LONGER THAN ONE YEAR FROM THE DATE ON WHICH IT IS SIGNED.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ DATE _____

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT _____

PROHIBITION OF REDISCLOSURE
THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTETED BY FEDERAL CONFIDENTIALITY RULES (41 CRF PART 2) AND STATE REQUIREMENTS (IOWA CODE, CH 228). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURES OF INFORMATION IN THIS RECORD THAT IDENTIFIES A PATIENT AS HAVING OR HAVING HAD A SUBSTANCE USE DISORDER EITHER DIRECTLY, BY REFERENCE TO PUBLICLY AVAILABLE INFORMATION, OR THROUGH VERIFICATION OF SUCH IDENTIFICATION BY ANOTHER PERSON UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE INDIVIDUAL WHOSE INFORMATION IS BEING DISCLOSED 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 (SEE § 2.31). THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO INVESTIGATE OR PROSECUTE WITH REGARD TO A CRIME ANY PATIENT WITH A SUBSTANCE USE DISORDER, EXCEPT AS PROVIDED AT §§ 2.12(C)(5) AND 2.65.