AUDUBON COUNTY MEMORIAL HOSPITAL & CLINICS

Authorization To Obtain or Release Protected Health Information

Patient Name _____**DOB**_____**MR#**_____

I, (Insert Name of Patient or Guardian) _____ **authorize** the exchange of written or oral health information (*two-way or reciprocal*) about my needs and the services I receive.

From the Following Individual Or Agency:

Name of Agency:	
Address:	
City/State/Zip:	
Phone:	Fax:

To the Following Individual Or Agency:

Name of Agency:	
Address:	
City/State/Zip:	
Phone:	Fax:

Relationship to Patient: _____ ☐ Self ☐ Spouse ☐ Parent ☐ Legal-Guardian ☐ Provider ☐ Other_____

For the Purpose of: ☐ Continuing Medical Care ☐ Personal Records ☐ Transferring Care ☐ Moved ☐ Other_____

Pick the following method to deliver record:

☐ Fax to_____ ☐ Mail to_____ ☐ Will pick up@_____ On_____

☐ **Date(s) of Service/Episode Requested**_____

Mark Below Type(s) of Health Information Requested:

☐ Emergency Record ☐ Consultation Report ☐ Inpatient ☐ OBS ☐ Skilled Records ☐ Social History Information
☐ Operative Report ☐ Pathology Report ☐ Laboratory Report ☐ Radiology Report ☐ Radiology Images/Reports
☐ Psychological Reports ☐ Treatment and Aftercare Plans ☐ Receiving Phone Calls ☐ History & Physical Exam
☐ Evaluation & Recommendations
☐ Consultation reports from (doctor/specialty name):
☐ Other (please specify): _____
☐ Entire Records From: _____ To _____

Limitations:

I specially authorize the release of:
☐ **Mental Health records** **Initial** _____
☐ **Substance Abuse records** **Initial** _____
☐ **HIV/AIDS information** **Initial** _____

Patient/Representative Signature _____**Date** _____
Representative's Relationship to the Patient _____ **Date** _____

****Patients seeking authorization for release of mental health records through Touching Lives Center must contact them directly.****

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit 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 information to criminally investigate or prosecute any alcohol or drug abuse patient. See

also Chapter 228 and Chapter 141A of the Iowa Code and other applicable laws. **If mental health information is being disclosed, I acknowledge receipt of a copy of the Authorization.**

I understand any Federal/State law protected health information of more sensitive information listed in this box will be included;

- This authorization is valid for information already in existence and any information that may be generated while this authorization is effective.
- I understand that I may inspect this information and I may request copies for a fee.
- I understand that I may revoke this authorization at any time by notifying Health Information Management in writing; however, the revocation will not apply to information already released in accordance with the authorization.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, except as permitted by law.
- I understand that the information disclosed may be re-disclosed by the recipient and no longer protected by the federal patient privacy and security regulations. The recipient may, however, be prohibited from disclosing substance abuse, and/or mental health information under federal regulations.
- I understand this authorization will expire 365 days from the signature date.
- I understand a copy of this authorization is available to me upon request.

_____ _____ _____

Signature of Patient or Legal Representative **Relationship** **Date**

_____

Witness Signature

IF VERBAL REQUEST was received, complete this section;

Name of Person Requesting Records_____

Will be picked up by_____

On (date)_____ **@ (location they can pick up the records):**

_____

Witnesses (Must have 2): _____**/**_____

Date_____

WHO COMPLETED FORM: _____

TO BE COMPLETED WHEN ACMH STAFF RELEASES RECORDS:

Staff: Did you confirm patient has on file a POA or Appointment of Representative: ☐ **Yes** ☐ **No** ☐ **N/A**

Who Released Records _____

Date_____