CONSENT TO RELEASE OF INFORMATION

Hosp. #: _____

University of Iowa Hospitals and Clinics (UIHC)

Please PRINT (except signatures) and provide complete answers (information) in each section.

Patient Name _____ Birth Date _____ Soc. Sec. # _____

I understand that by signing this form I am allowing UIHC to release medical information concerning the above-named patient to:

_____

Name of Person and/or Institution

_____

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates where indicated): ☐ Minimum necessary or specify:

☐ Medication list ☐ Allergy list ☐ Immunization record ☐ Problem List (Patient Summary List)

☐ Most recent history and physical or specific date(s) _____

☐ Most recent discharge summary or specific date(s) _____

☐ Laboratory results, specify types or dates _____

☐ X-ray and imaging reports, specify types or dates _____

☐ Consultation reports from (doctors' names or clinic) _____

☐ Test results (i.e., EKG, PFT, etc.), specify type and date _____

☐ Billing Info. _____

☐ Other, specify: _____

As per my request, reason for release of information: ☐ medical care ☐ legal ☐ insurance ☐ other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Director of Health Information Management, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, IA 52242. I understand that any release that was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address.

I understand that UIHC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____.

* _____

Signature of Patient or Legal Guardian Date

_____

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____ _____

Relationship, if Not the Patient Witness Signature

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

I specifically authorize the release of data and information relating to the following (check the appropriate box or boxes):

☐ Substance Abuse ☐ Mental Health ☐ HIV-Related Information

* _____

Signature of Patient or Legal Guardian Date

***IN ORDER FOR THIS SPECIFIC INFORMATION TO BE RELEASED, YOU MUST SIGN HERE *AND* ABOVE, AND CHECK THE APPROPRIATE BOX(ES).**

UIHC use only: Upon satisfying release, date & sign, record on ROIT system and file form in back of medical record. If unable to enter release on ROIT system, forward to Release of Information Office, HIM, 2 SRF.

Info. sent/viewed: _____ Recorded on ROIT System: _____

Name/Department Date Operator Name/Department Date

FORM 1989
38774/4-03/MH01359/1

Lavender Original: Medical Record
Canary Copy: Patient