

# AUTHORIZATION TO RELEASE PATIENT INFORMATION



Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. A copy of this signed form will be provided to the patient upon request. The release is not valid without original signature and date signed by client.

I hereby authorize Story County Medical Center, Nevada, Iowa and/or Story Medical Clinics, Nevada, and Maxwell, Iowa, or other: \_\_\_\_\_

Facility Name	Address	Phone #	Fax#
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to disclose information from the health records of:  
Name: \_\_\_\_\_

Last	First	MI	Previous Name
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DOB	Telephone #	(Home)	(Work)	(Cell phone)
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This information is to be disclosed to: \_\_\_\_\_

Covering the periods of healthcare: Date(s) of service:  
From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

For the purpose of: \_\_\_\_\_

- Any/all or as much information as the releasing healthcare provider, in its sole discretion, deems reasonably necessary for the purpose set forth by me for release.
- Discharge Summary       History & Physical       Operative Report       Pathology Report
- Consultation Report       Laboratory, X-ray, EKG       Emergency Room
- Other (please specify) \_\_\_\_\_

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

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

Mental Health treatment     
  Drug or Alcohol Abuse treatment     
  HIV/AIDS test results

\* Signature: \_\_\_\_\_

\* In order for this information to be released, you must sign here and below, and check the appropriate box(es).

This authorization is effective for \_\_\_\_\_ months but no longer than one year from the date on which it is 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 Director of Health Information Department at Story County Medical Center.

I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Story County Medical Center and Clinics.

I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand this authorization is voluntary.

**PROHIBITION OF REDISCLOSURE**

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, and HIV/AIDS test results, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch.228 & ch.141) prohibit further disclosure without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug abuse or mental health related information or HIV/AIDS test results.

\_\_\_\_\_  
Signature of Patient or Patient's Authorized Representative

\_\_\_\_\_  
Relationship of Authorized Representative

\_\_\_\_\_  
Date

Date Information released \_\_\_\_\_ Released by \_\_\_\_\_

Hospital - 640 S 19th Street	Nevada, Iowa 50201	Phone: 515-382-7715	Fax: 515-382-7762
Nevada Clinic - 640S 19th Street	Nevada, Iowa 50201	Phone: 515-382-5413	Fax: 515-382-7107
Maxwell Clinic - 403 1st Street	Maxwell, Iowa 50161	Phone: 515-387-8815	Fax: 515-387-8817