Adair County Medical Clinics

Greenfield Clinic
609 SE Kent
Greenfield, Iowa 50849
(641) 743-6189

Stuart Clinic
303 SW 7th St., Suite B
Stuart, Iowa 50250
(515) 523-2513

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH 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. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below.

I hereby authorize ___________________________ to disclose the following information from the health records of:

Name: ____ **Previous or Parent Name:** _____________________________________

Date of Birth: ________________ **Social Security #** ______________ **Phone (H):** _______________ **Phone (W):** __________________

Address: ____

Street *City* *State* *Zip*

This information is to be disclosed to:

____

Covering the periods of healthcare (dates of service): **From:** ________________________ **To:** ___________________________

For the purpose of:

☐ Transferring medical care ☐ Moving ☐ Insurance Coverage ☐ Other: ___________________________

(Not required if the disclosure is requested by the patient)

The following information may be released:

☐ Complete records ☐ Lab Data ☐ EKG ☐ X-ray data ☐ Immunization Record ☐ History and Physical

☐ Discharge summary ☐Other: ____

SPECIFIC AUTHORIZATION FOR RELEASE OF ADDITIOANL PROTECTED INFORMATION

I understand that if I check and initial the box below this release will release information relating to:

- ☐ Acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV)
- ☐ Behavioral health service/psychiatric care
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Genetic information and/or testing results

If compensation will be received: I understand that __________________________ will receive compensation for its use/disclosure of the information release pursuant to the is authorization.

Patient Initials ☐

Affirmation of Release

I give the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

____ ____

Signature of the Patient Guardian/Legal Representative Date Signed Signature of the Witness Date Signed

Expiration date: _______________ (One year from date signed)

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, federal requirement(42-C.R.F. Part2) and state requirements(Iowa Code ch.228) prohibit further disclosure without the specific written consent of the patient or as otherwise permitted by such law or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information