

**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 \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**This information is to be disclosed to:**

\_\_\_\_\_

**Covering the periods of healthcare (Date(s) 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  Immunization Record  
 Lab Data  History and Physical  
 EKG  Discharge Summary  
 X-ray Data  Other \_\_\_\_\_

**Specific Authorization for Release of Additional Protected Information:**

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

- Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.  
 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 this authorization. Patient's 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 \_\_\_\_\_ Date Signed \_\_\_\_\_ Signature of Witness \_\_\_\_\_ Date Signed \_\_\_\_\_  
Guardian/Legal Representative

Expiration date: \_\_\_\_\_ (One year from date signed)

**English**--Adair County Medical Clinics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**Espanol (Spanish)**—Adair County Medical Clinics cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

**Français (French)**—Adair County Medical Clinics se conforme aux lois fédérales applicables en matière de droits civils et ne fait aucune discrimination fondée sur la race, la couleur, l'origine nationale, l'âge, le handicap ou le sexe.

**English-ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 641-743-2123

**Español (Spanish)-ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 641-743-2123

**Français (French)-ATTENTION :** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 641-743-2123

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