

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS



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- Send records **TO** Family Practice Center
- Send records **FROM** Family Practice Center USB Drive Fax Paper
Unless noted, records will be sent in PDF format on USB flash drive.
- Release to **SHARE** information with _____
- Release to **SHARE** information with Employer: YES NO (circle one)

Print Patient Name: _____ Phone: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Address (street, city, state, zip): _____

RELEASE RECORDS **FROM**: _____

Address (street, city, state, zip): _____

RELEASE RECORDS **TO**: _____

Address (street, city, state, zip): _____

- Send: Complete Records Progress Notes: Dates _____
- Lab Records: Dates _____ Radiology Reports: Dates _____
- EKGs': Dates _____ Hospital Reports: Dates _____
- Immunization Records Other: _____

Reason: Transferring Care Second Opinion Moving Other: _____
(Please Explain)

If worker's compensation or FMLA, may we release information to your employer? YES NO

STATE AND FEDERAL LAW REQUIRES A YES OR NO ANSWER TO THE FOLLOWING AUTHORIZATION FOR RELEASE OF THE FOLLOWING INFORMATION. (For more information, see reverse side of this form)

If contained within my medical records, the following information may be released:

- * Substance Abuse Yes No (includes tobacco use, alcohol, controlled substance, etc.)
- **Mental Health Yes No (includes headaches, stress, anxiety, depression, etc.)
- HIV/AIDS-Related Yes No (includes diagnosis, HIV/AIDS-related testing)

I understand one of my rights from the Notice of Privacy Practices that I may revoke this authorization at any time by sending a written notice to the above letterhead institution and it will not become effective until received by the Privacy Officer. In situations where 1) prior, to my revocation, any release made in reliance upon this authorization; or 2) authorization was obtained as a condition of obtaining insurance coverage & other law provides insurer with right to contest a claim under the policy does not constitute a breach of my rights to confidentiality. I also understand that I may review the disclosed information by contacting the Privacy Officer at above stated institution and that recipients of this information may possibly re-release the information without prior authorization. I hereby acknowledge that I have read this release form, or it has been read to me, and I understand its content.

This authorization will expire in one year or: Never As of _____

Signature of patient or legal representative Date

Relationship, if not the patient Date Information copied/Sent _____

Witness (**This must be signed or release is invalid**) Date

Northeast Iowa Family Practice Center does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.

FROM FRONT SIDE OF FORM:

- * Only the client, regardless of age, can authorize release of substance abuse information
- ** Only the client, 18 years of age or older or a legal representative, can authorize release of mental health information.

By law, a signed medical release is NOT required for DHS requests, workers' compensation requests, or for immunization records.

HIPAA PRIVACY RULE AND PROHIBITION ON REDISCLOSURE

This form does not authorize re-disclosure of medical information beyond the limits of this authorization. Any information that was used/disclosed prior to this authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA Privacy Rule. Any HIV-or AIDS-related information has been disclosed from records whose confidentiality is protected by state and federal law. Where information has been disclosed from records protected by federal requirements (42 CFR 2) and state requirements (Iowa Code Chs. 141 and 228) 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 the release of medical or other information is NOT sufficient for these purposes. The federal rules restrict any use of this information to criminally investigate or prosecute an alcohol or drug abuse patient. Civil and/or criminal penalties may attach for unauthorized re-disclosure of alcohol/drug abuse, HIV or mental health information.

Miscellaneous Medical Release Information:

Release to Patient's Family: Information concerning the status of the patient may only be disclosed to those parties or individuals related to or having a personal relationship with the patient upon receipt of the patient's written authorization.

Birth Control: Whenever documentation in the medical record indicates that an individual has received treatment for birth control, only the patient can authorize release of that specific information. This holds true for minors.

Authorizations by Minors: Legally emancipated, married, or those minors who are parents of a child may consent to their own treatment and, as such, are the only ones legally authorized to consent to the release of information from their records.

Minors who have been treated for venereal disease, contraception, have received an abortion, or who have been treated for alcohol or substance abuse are the only persons able to authorize the release of this type of information. (Even if a patient paid for the services, they are not legally entitled to records of this nature)

Emancipated Minors: When a minor is married, the parent of a child, lives apart from parents, and is self-supporting, they are considered emancipated minors. The emancipated minor has the same authority as an adult regarding release of medical records.

Paternity and Other Guardianship Issues: Iowa law states that if proof of parenthood by birth certificate, blood (sperm) test, and if possible, copies of child support payments; that parent has the right to the child's medical records.

If a physician has sound reason for believing access to the records would be harmful to the patient's health or well-being, direct patient access may be denied. Medical records are recognized as the property of the physician or the health care facility.

This general and special authorization to disclose was developed to comply with provisions regarding disclosure of medical, educational and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

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