Henry County
HEALTH CENTER

Authorization of Release of Information

***a fee for reproduction may be assessed**

Section A: Must be completed for all authorizations
I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Patient Name: _____ Last Four of SSN: _____ DOB: _____

Address: _____ Phone: _____

To/From (circle one)
Henry County Health Center
Health Information Services
407 S White Street
Mt. Pleasant, Iowa 52641
Ph: 319.385.6139 Fax: 319.385.6573

To/From (circle one)
_____
_____
_____
_____

Type of information requested (Last two years will be sent unless otherwise indicated.):

Surgery	Discharge Summary	Immunizations	Emergency Room	X-ray/Imaging Report
Lab	Office Visit Notes	History & Physical	Other: _____	

Purpose of Release

Insurance	2nd Opinion	Rehab/Disability	Moving Out of Area
Legal	Transferring Care	Wish to not Disclose	Other: _____

I understand that all information may be release electronically, and may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).
_____ Substance Abuse _____ Mental Health _____ HIV-Related Information _____ Genetic Testing/Info

Section B: Patient must read and sign below
- This authorization is effective for 12 months. I understand that I may revoke this authorization at any time in writing except to the extent that action has already been taken in reliance upon it, by giving written notice to the Director of Health Information.
- I understand that authorizing the disclosure of this information is voluntary; I can refuse to sign this authorization. I need not sign this for in order to receive further treatment.
- I understand that I have the right to inspect the information to be disclosed upon proper notification and under appropriate conditions established by above named facility. The facility, its employees, officers, and attending physicians are released from legal responsibility or liability for release of above information to the extent indicated and authorized herein.
- I understand that I am authorizing the release of data and information relating to any/all substance abuse, mental health, HIV related information or assault and/or abuse information if not restricted in the specific description above.
- I have personally received and assumed responsibility for any information I have received if transporting to another physician or institution listed above.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above my be redisclosed and no longer protected by those regulations.

I hereby acknowledge that I have received a copy of this document.

Signature of Patient or Authorized Representative: _____ Date: _____
Authorized Representative Relationship to patient: □Parent □Power of Attorney □Guardian □Other: _____

PROHIBITION OF REDISCLOSURES

This form does not authorize redisclosure of medical information beyond the limits of this authorization Where information has been disclosed from records protected by Federal Law for alcohol/drug records (42 CFR Part 2), for mental health records (Iowa Code CH 228), or HIV/AIDS records (Iowa Code CH 141), federal requirements and state requirements 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 information is not sufficient for these purposes. Once PHI is disclosed to others, it may be redisclosed to individuals or organizations not subject to HIPPA and may no longer be protected by HIPPA.

A photocopy, or exact reproduction of this authorization, as duly executed, shall have the same force and effect as the original.

OFFICE USE ONLY
Completed By: _____ Dept.: _____ Date: _____
Via: □FAX □EMAILED □MAILED □GIVEN TO PATIENT □OTHER