Great River HEALTH

AUTHORIZATION TO RELEASE INFORMATION

Great River Health (GRH)
Health Information Management Department; 1221 S. Gear Ave., West Burlington, IA 52655
Telephone: 319-768-1900 Fax: 319-768-1970 Email: customerresourceteam@greatriverhealth.org

Patient legal name____ **Date of Birth**____________

List previous names (maiden, married, legal changes)____

GRH site to release information from:

- ☐ Southeast Iowa Regional Medical Center – Hospital and Clinics
- ☐ Klein Center
- ☐ Southeast Iowa Regional Home Health & Hospice
- ☐ Henry County Health Center – Hospital and Clinics (HCHC Campus/Keokuk/New London/Wapello/Winfield/Wayland)
- ☐ Specific Clinic/Provider only (name clinic/provider)______________________________________

Send records to:
Name and/or facility____

Complete mailing address____

Format to be released: ☐ Electronic ☐ Paper ☐ Fax____________
☐ Email______________________________________

Information to be released (will be previous 1 yr unless specified below):

☐ Discharge Summary	☐ History and Physical	☐ Operative Report	☐ Pathology Report
☐ Emergency Department	☐ Clinic Notes	☐ Medications	☐ Immunizations
☐ Consultations	☐ Radiology Images	☐ Radiology Reports	☐ Lab Reports
☐ Other test results	☐ Billing Records	☐ Formerly Fort Madison Hospital records	

☐ Formerly Great River Medical Center records ☐ Formerly Burlington Medical Center records
☐ Formerly Great River Clinic records (Specify clinic)____
☐ Formerly Fort Madison Clinic records (Specify clinic)____

Date(s)_________________**to**____________________

Reason for release: ☐ Insurance ☐ Legal ☐ Continued Care ☐ Other________________

I understand that the information to be released may include information in the following categories unless I specifically deny the request (***check any category NOT to be released***)
☐ Substance Use* ☐ Mental Health ☐ HIV related information ☐ Genetic information**
*Information disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits the unauthorized redisclosure of these records). ** Refers to genetic testing for possible future health issues; does not refer to testing to diagnose or treat current health conditions.

By signing this authorization form, I understand that:

- This consent may be cancelled by sending written notice to: Manager, Health Information Management, Great River Health, 1221 S. Gear Avenue, West Burlington, IA 52655.
- If the authorization is cancelled, I understand information may have been released prior to cancellation, and that action would not be considered a breach of confidentiality.
- I also understand that recipients of this information may possibly re-release the information without proper authorization and that once it has been disclosed, it may no longer be protected by federal privacy regulations.
- GRH does not require completion of this form as a condition of treatment or payment, however, if the service is solely for the purpose of creating a medical report for a third party or participating in research related treatment, refusal to sign this form may result in cancellation of those services.

This authorization will expire one year (12 months) from the date signed or as specified here _____days/months

Signature:____Date____________________________
(Patient or legal representative only)

Printed name of person signing:____

Relationship____

STAFF ONLY Reproductive Health Attestation Required? (circle) Yes / No Reproductive Health Attestation Obtained (circle) Yes / No