AUTHORIZATION TO RELEASE PATIENT INFORMATION

Story County Medical Center

An Affiliate of UnityPoint Health

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. A copy of this signed form will be provided to the patient upon request. The release is not valid without original signature and date signed by client.

I hereby authorize Story County Medical Center, Nevada, Iowa and/or Story Medical Clinics, Nevada, and Maxwell, Iowa, to disclose information from the health records of patient listed below. **Or to obtain from other facility: _____.**
Other Facility Name

_____
Other Facility Address Phone # Fax #

Name:_____
Last First MI Previous Name

_____
DOB Telephone # (Home) (Work) (Cell phone)

Address: _____
Street City State Zipcode

This information is to be disclosed to: _____

Covering the periods of healthcare: Date(s) of service:
From (date) _____ to (date) _____

For the purpose of: _____

☐ Any/all or as much information as the releasing healthcare provider, in its sole discretion, deems reasonably necessary for the purpose set forth by me for release.

☐ Discharge Summary ☐ History & Physical ☐ Operative Report ☐ Pathology Report
☐ Consultation Report ☐ Laboratory, X-ray, EKG ☐ Emergency Room
☐ Other (please specify) _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: (check appropriate box(es)

☐ Mental Health treatment ☐ Drug or Alcohol Abuse treatment ☐ HIV/AIDS test results

* Signature: _____

* In order for this information to be released, you must sign here and below, and check the appropriate box(es).

This authorization is effective for _____ months but no longer than one year from the date on which it is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Director of Health Information Department at Story County Medical Center.

I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Story County Medical Center and Clinics.

I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer by protected by federal privacy regulations. I understand this authorization is voluntary.

PROHIBITION OF REDISCLOSURE

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, and HIV/AIDS test results, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch.228 & ch.141) 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 release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug abuse or mental health related information or HIV/AIDS test results.

_____
Signature of Patient or Patient's Authorized Representative

_____
Relationship of Authorized Representative

_____
Date

Date Information released_____ Released by_____

Hospital - 640 S 19th Street Nevada, Iowa 50201 Phone: 515-382-7715 Fax: 515-382-7762
Nevada Clinic - 640 S 19th Street Nevada, Iowa 50201 Phone: 515-382-5413 Fax: 515-382-7107
Maxwell Clinic - 403 1st Street Maxwell, Iowa 50161 Phone: 515-387-8815 Fax: 515-387-8817