WAYNE COUNTY HOSPITAL AND CLINIC SYSTEM
AUTHORIZATION FOR ACCESS, USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (please print) _____ Medical Record # (for office use only) _____

Birth date _____ Social Security # _____ Phone (home) _____

Address _____

City _____ State _____ Zip Code _____

I, the undersigned authorize and request Wayne County Hospital and Clinic System to:
☐ allow access, use, or disclosure of my protected health information to: **OR** ☐ obtain from:

Person/Organization _____

Address _____

City _____ State _____ Zip Code _____ Phone _____ Fax _____

Date(s) of Service: _____ ☐ **Copies as indicated below** ☐ **Review only**

☐Discharge Summary ☐History and Physical ☐Emergency Room Note ☐Progress Notes ☐Operation Report ☐Consultation Report
☐Radiology Report/IMD/CD of films ☐EKG ☐Pathology Report ☐Laboratory Results ☐PT, OT, ST Eval/Notes ☐ Clinic Notes
☐Other: _____

Please explain why you are requesting access, use or disclosure to the above mentioned health record:
☐ Continuing Medical Care ☐ Transfer Care ☐ Insurance ☐ Personal ☐ Legal ☐ Other: _____

I specifically authorize the release of records that may include protected confidential information regarding:
Drugs or alcohol use/abuse, Initial: _____ Mental Health, Initial: _____ HIV/AIDS, Initial: _____

I authorize my information to be: ☐ Mailed to:, ☐ Faxed to:, OR ☐ Pick up by: _____

Wayne County Hospital and Clinic System may impose a fee to cover the cost of labor, copying, postage, and preparing a summary of the requested information. Do you agree to such fees imposed by Wayne County Hospital and Clinic System for providing a copy or summary of the requested information? ☐ YES ☐ NO

Prohibition on Conditioning of Authorization: Wayne County Hospital and Clinic System will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with healthcare is to make a report to a third party, such as your employer (e.g., P.E., Physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, and State Law (Iowa Code ch. 228 & 141A) for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, 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. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Civil and Criminal Penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/AIDS information.
Expiration: This authorization is will expire **one year** following the date of signature except in the case of continuing care.
Revocation: I understand that I may revoke this authorization at any time by notifying Wayne County Hospital and Clinic System in writing by sending a letter to ***Wayne County Hospital and Clinic System***, ***Health Information Management Department***, 417 S. East Street, Corydon, IA 50060, Phone: (641) 872-5263, Fax: (641) 872-3656 or completing the Revocation for Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Wayne County Hospital and Clinics took before it received my revocation letter.
This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Wayne County Hospital and Clinic System's Notice of Privacy Practices.

Signature of Patient or Personal Representative _____ Date _____

If other than the patient, state relationship and reason patient is unable to sign _____

For Wayne County Hospital and Clinic System's Use Only: Witness/Received by _____ Date _____
Patient Identification Verified: ☐ YES ☐ NO /☐ Request Accepted ☐ Denied (see denial page)