Wayne County HOSPITAL
An Affiliate of MERCYONE

WAYNE COUNTY HOSPITAL AND CLINIC SYSTEMS
417 S EAST ST ● CORYDON, IA 50060
PHONE: 641-872-5263 ● FAX: 641-872-3656

Authorization/Request for Release of Medical Information

Instructions **PATIENT INFORMATION**	**Make sure all blanks are filled in. Failure to do so could prevent or delay processing.** Name (Legal/Maiden/Other) _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Date of Birth: _____
RELEASING ENTITY (Who is authorized to release the information)	Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
RECEIVING ENTITY (Where do you want the information sent)	Requestor Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
INFORMATION REQUESTED (Charge may apply)	Service Dates: _____ ☐ Pertinent Records-Most recent office visits, hospital visits, operative reports, and testing. ☐ Entire Record ☐ Discharge Summary ☐ History & Physical ☐ Emergency Room Note ☐ Operative/Procedure Note ☐ Consultation Note ☐ Clinic Notes ☐ PT/OT/ST Eval/Notes ☐ EKG/Cardiology Testing ☐ Immunization Record ☐ Radiology Report/IMD/CD of films ☐ Laboratory Results/Pathology Report ☐ Other: _____
PURPOSE OF RELEASE (Check all that apply)	☐ Continuing Medical Care ☐ Transfer of Care ☐ Insurance ☐ Personal Use ☐ Legal ☐ Moving ☐ Other: _____
REQUESTED FORMAT	☐ Paper ☐ CD (Password Protected) ☐ Mailed ☐ Faxed to: _____ ☐ Call: _____ at Phone# _____ ☐ Pick up, Date: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
PLEASE CHECK EACH BOX YOU <u>DO NOT AUTHORIZE</u>

I specifically do not authorize the release of information which may include or relate to:
☐ Substance Use/Abuse ☐ Mental Health ☐ STD/HIV-related information ☐ Genetic Information

_____ _____
Signature of Patient or Legal Representative Relationship

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Prohibition on Conditioning of Authorization: Wayne County Hospital and Clinic Systems will not condition treatment, payment or enrollment/eligibility for benefits on signing this authorization unless:

- You are receiving research-related treatment or
- The only reason the facility is providing you with health care is to make a report to a third party such as your employer (e.g., fitness to return to work) or school (e.g., athletic participation).

EXPIRATION: This authorization is effective for _____ months but no longer than one year from the date on which it was signed.

REVOCATION: I understand I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving a written notice.

INSPECTION: I understand I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Wayne County Hospital and Clinic Systems.

PLEASE BE AWARE THERE MAY BE A FEE ASSOCIATED WITH YOUR REQUEST

The statements made in this authorization are binding, controlling and I understand that they take precedence over statements in the organization's Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient, if not signed by the Patient

_____
Witness

PROHIBITION OF REDISCLOSURE
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2) and state requirements (Iowa Code, ch 228). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provider at §2.12(c)(5) and 2.65.

OFFICE USE ONLY:

Date Information Sent: _____ Person Releasing Records: _____

Fee Due: _____ Fee Paid: _____