IOWA HEART CENTER

MEDICAL RECORDS RELEASE OF INFORMATION DEPARTMENT:

5880 UNIVERSITY AVE, STE 209 • WEST DES MOINES, IA 50266 • PHONE: 515-633-3880 • FAX: 515-246-4485

AUTHORIZATION TO RELEASE INFORMATION

COMPLETE ALL FIELDS AND PRINT CLEARLY. FAILURE TO DO SO MAY PREVENT OR DELAY RELEASE OF INFORMATION.

Patient Name _____
Last First Middle Initial

Address _____
Street City State Zip Code

Phone (____) _____ Date of Birth _____ Soc Sec # _____ Acct # _____

I authorize information from my medical record to be released (please include address & fax if available) –

SEND FROM:
Person/Place: _____
Address: _____
_____
Phone/Fax: _____

SEND TO:
Person/Place: _____
Address: _____
_____
Phone/Fax: _____

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

*PLEASE CHECK EACH BOX **YOU DO NOT** AUTHORIZE*

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**

PLEASE INDICATE RECORDS TO BE RELEASED –

☐ Pertininent records - Most recent office visits, hospital visits, Operative reports, and testing

☐ Medical records from dates of service _____ to _____

☐ Testing (Please specify) _____

☐ Other (Please specify) _____

Reason for Request: ☐ Continued Care ☐ Transferring Care ☐ Insurance ☐ Personal ☐ Moving ☐ Legal

☐ Other (please describe): _____

Please be aware that Iowa Heart Center may impose a fee to cover costs involved in processing this release of information

Prohibition on Conditioning of Authorization: Iowa Heart Center 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 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).

Redisclosure: 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 my 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 & 141) 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 effective until (day, month, year) _____ or expiration of event (eg end of research study) but no longer than 1 year from the date on which it is signed.

Revocation: I understand that I may revoke this authorization at any time by notifying Iowa Heart Center in writing by sending a letter to the Iowa Heart Center Medical Records Department (address at top of this form) or completing the Revocation for Authorization form. I understand that if I revoke this authorization it will not affect any actions that Iowa Heart Center took before it received my revocation letter.

I understand that I have the right to review or receive a copy of the information to be disclosed, upon request. The statements made in this authorization are binding, controlling, and I understand that they take precedence over statements made in the Iowa Heart Center Notice of Privacy Practices (available upon request).

Patient Signature (or Legal Representative): _____ Date: _____

If Not Signed By Patient State Relationship: _____

FOR OFFICE USE ONLY: Completed By: _____ Location: _____ Date: _____ Fee Due: _____ Fee Paid: _____