IOWA PSYCHIATRY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ (patient), _____(DOB) authorize Iowa Psychiatry (2327 70th Street, Urbandale, Iowa 50322; P: 515-270-2242; F: 515-777-1950) to

☐ **Release** medical records to the individual/organization below

☐ **Request** medical records from the individual/organization below

Physician/Organization/Individual_____

Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____ Fax Number:_____

For the following use, purpose, or need:

☐ Coordination of care ☐ Continuity of care ☐ Legal ☐ Insurance ☐ Personal Use

☐ Other (Specify)_____

The following information may be disclosed, covering dates from _____ to _____

☐ Complete records ☐ Office Notes ☐ Communication Only

☐ Other (Specify)_____

Specific Authorization for Release of Information protected by State or Federal Law

Please Initial or Check next to each to authorize the specific release of each of the following:

☐ Mental Health ☐ HIV/AIDS ☐ Substance Abuse/Alcohol/Drugs ☐ Genetic Testing

Signature of Patient/Legal Representative: _____Date:_____

Witness:_____Date:_____

I understand that I have the right to request a copy of this form after I sign it. I understand that this authorization is subject to written revocation at any time; however, I understand that revocation of this authorization will not affect any actions taken before the revocation was received or actions taken in reliance thereon. I also understand that this authorization will expire in one year from the date signed, unless I specify otherwise. I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from whom disclosure is sought in writing. I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I agree that the information may be faxed for expediency. I acknowledge and authorize that the information indicated on this form will be sent to the individuals/organizations listed above. I understand that I have a right to access my treatment records. Copies of records may be obtained with reasonable notice and a fee may be charged for the copying of records. Uses and disclosures of protected health information may be permitted without prior consent in the event of an emergency, when a provider is required by law to treat the individual, or when there are substantial communication barriers. Protected health information may be released to healthcare providers who have indirect relationships with patients, such as laboratories, health plans, and healthcare clearinghouses. Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information much be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Se also Chapter 228 and Chapter 141(A) of the Iowa Code and other applicable laws.

NOTE: PHOTOCOPY OF THIS SIGNED AUTHORIZATION SHALL BE AS EFFECTIVE AS THE ORIGINAL

Updated 3/19/19 MEL