Authorization to Release Protected Health Information

Instructions: <u>All</u> sections need to be completed to be a valid authorization.

Legal Name (Last, First, Middle)		Previous Name	Medical Record Number
Address		Phone Number	Cell Phone Number
City	State	Zip Code	Birth Date

Release of Information TO:

☐ Hancock County Health System
532 1st St NW, Britt, IA 50423
Fax #: 641-843-5234
Email: hchsmedrec@mercyone.org

☐ Other: Name: _____
Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Fax #: _____

☐ **Urgent Request for Medical Records to HCHS**
Please return to:
Name: _____
Fax #: _____

Release of Information FROM:

☐ Hancock County Health System
532 1st St NW, Britt, IA 50423
Fax #: 641-843-5234
Email: hchsmedrec@mercyone.org

☐ Other: Name: _____
Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Fax #: _____

Information to be Released:

☐ Any/All information being requested

☐ Other _____

Special Release: I specifically authorize the release of:

☐ Yes ☐ No Mental Health records Initial: _____

☐ Yes ☐ No Substance Abuse records Initial: _____

☐ Yes ☐ No HIV/AIDS information Initial: _____

☐ Yes ☐ No Genetic Testing Initial: _____

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 information to criminally investigate or prosecute any alcohol or drug abuse patient. See also Chapter 228 and Chapter 141A of the Iowa Code and other applicable labs. **If mental health information is being disclosed, I acknowledge receipt of a copy of this Authorization.**

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Health Information Dept. I understand that any release, which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand as a patient I have the right to access my records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand Mercy Medical Center –North Iowa and Affiliated Clinics/Hospitals may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in a denial of those services. By signing this release, I am consenting to the use of my health information per the notice of privacy practices. This authorization will expire on the following date, event, or condition. **If I fail to specify, this authorization will expire in twelve (12) months.** A photocopy of this signed authorization shall be as effective as the original.

Patient/Representative Signature:	Date:	Representative's Relationship to Patient:
Witness Signature:	Date:	**Information picked up:** Date: _____ ☐ Photo Identification Verified Staff Initials: _____

REVOCATION OF DESIGNEE I hereby revoke designation of my Hancock County Health System patient information to the individual named below. I understand this revocation is in effect going forward and does not prevent this individual from using or disclosing information obtained during the time she/he served as my designee.

Patient's Signature: _____ Date: _____ Time: _____
Witness: _____ Date: _____ Time: _____