



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Name: _____
Last First MI

Date of Birth: ____/____/____ Social Security #: _____-____-_____

Address: _____
Street City State Zip code

Phone Number: _____ Medical Record #: _____

INFORMATION BEING SENT TO/FROM

(check only one)

This information is to be released **FROM** UnityPoint Health – Keokuk to the facility or individual below:

Name: _____
Address: _____

Initial to permit fax release for immediate or emergency patient care needs.

Fax #: _____

This information is to be released **TO** UnityPoint Health – Keokuk

Dept Name: _____

From the facility or individual specified below:

Address: _____
Phone #: _____

TYPE OF INFORMATION BEING REQUESTED

For Date(s) of service: _____
 Discharge Summary History & Physical Report ER Report
 Laboratory Report X-Ray Report _____ film Consultation
 Pathology Report Physician's Orders Operative Report
 Other (specify): _____

SPECIFIC AUTHORIZATION FOR RELEASE FUTHER PROTECTED BY STATE OR FEDERAL LAW. IF THE INFORMATION ABOVE INCLUDES MENTAL HEALTH TREATMENT, SUBSTANCE ABUSE TREATMENT OR HIV-RELATED INFORMATION, IT WILL NOT BE RELEASED UNLESS YOU SPECIFICALLY AUTHORIZED BY INITIALING BELOW.

Initial any category to BE released:

Acquired Immunologic Syndrome (AIDS) or Human Immunologic Virus (HIV)
 Alcohol and/or drug abuse treatment
 Behavioral or mental health services

PURPOSE FOR DISCLOSURE

Patient Care Personal Use Insurance Claim Legal Purposes
 Employer Requirement Other (specify): _____

TIME LIMIT

I understand that I may cancel (revoke) this authorization at any time by sending a written notice to UnityPoint Health – Keokuk Health Information Department and that my cancellation will take effect when the written notice is received. The cancellation will not apply to information that has already been released in response to this authorization. This authorization will automatically expires three (3) months from the date of signature except as specified: _____

I understand that authorizing the disclosure of this health information is voluntary. I need not to sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provide or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations unless otherwise prohibited from re-disclosure under other federal and/or state laws and regulations.

SIGNATURE & DATE

Signature: _____ Date: _____

Relationship, if not patient: _____ Witness: _____

(A copy will be provided for patient)

Information processed & sent (date/initial): _____