UnityPoint Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to UnityPoint Clinic (UPC). I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the organization.

PATIENT IDENTIFICATION	Name (last, first, middle initial): _____ Date of birth: _____ Last 4 digits of soc. sec. #: _____ Any previous names under which records may be kept: _____ Telephone number where we can reach you if we have questions: (_____) _____
PROVIDER (Who is to disclose the information?)	☐ All affiliated clinics using the UnityPoint Clinic (UPC) Electronic Health Record ☐ Other entity (please specify): _____ Street address: _____ City, State, Zip: _____
RECIPIENT (Who is to receive the information?)	Name: _____ Street address: _____ City, State, Zip: _____ Telephone number: (____) _____ Fax number (if applicable): (____) _____
PURPOSE OF RELEASE (Check **all** that apply)	☐ At request of the patient (or legal representative) ☐ Discussion/coordination of care with family members involved with patient's care ☐ Transferring medical care to another health care provider ☐ For claims processing purposes (e.g., third-party liability claims) ☐ Other (please specify): _____
INFORMATION (What information should be released?) (Check all that apply)	☐ Records dating from: _____ to: _____ ☐ Only records created by specific clinic(s): _____ ☐ Records from other UnityPoint Clinics (if held in merged UPC electronic health record) _____ ☐ Records from other non-UPC clinics: _____ ☐ Other (please list specific records): _____

I understand my healthcare and payment for my healthcare will not he affected by this authorization.

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

I specifically authorize the release of information relating to: (check all that apply)

- ☐ Mental health
- ☐ HIV-related information (including AIDS and related testing)
- ☐ Substance abuse treatment (Alcohol/Drug)

Signature of patient or legal representative: _____ Date: _____

Relationship to patient, if signed by legal representative: _____

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse treatment records or by state law for mental health records, federal requirements (42 CFR Part 2) and state requirements prohibit further disclosure 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. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse treatment or mental health information.

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