



UnityPoint Health Authorization for Release of Medical Information

INSTRUCTIONS:	Make sure all blanks are filled in. Failure to do so could prevent or delay processing
PATIENT IDENTIFICATION	Name (Legal/Maiden/Other) _____ Address _____ City _____ State _____ Zip _____ Phone # _____ Date of Birth _____ Social Security Number (optional) _____
PROVIDER/ ORGANIZATION (Who is authorized to release the information)	Provider Name _____ Address _____ City _____ State _____ Zip _____
REQUESTOR: (Where do you want the information sent)	Requestor Name _____ Address _____ City _____ State _____ Zip _____
INFORMATION REQUESTED: <i>charge may apply</i>	Service Dates _____ <input type="checkbox"/> Abstract (all physician dictations/test results) <input type="checkbox"/> Lab/Radiology Results <input type="checkbox"/> Entire Record <input type="checkbox"/> Other, please specify _____
PURPOSE OF RELEASE:	(Check all that apply) <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance Coverage <input type="checkbox"/> Legal <input type="checkbox"/> SSA/Disability <input type="checkbox"/> Personal Use <input type="checkbox"/> Other _____
Requested Format:	<input type="checkbox"/> Paper <input type="checkbox"/> CD (Password Protected):

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

I authorize the release of the information listed below, which requires specific consent under federal law: (check all that apply) (Note: Depending on what is checked we may be unable to fulfill this authorization.)

- Substance Abuse Mental Health Treatment (excluding psychotherapy notes) HIV/AIDS related testing

Signature of Patient or Authorized Representative: X _____ Relationship _____

Witness Signature (Illinois Only): X _____

X _____
ILLINOIS ONLY: Minor's signature required if ages 12-17 for mental health records.

For Illinois or Wisconsin Residents Only: Under state law, you must separately and expressly authorize release of any of the following confidential information (check those that apply for your state): Genetic Testing (Illinois) Sexual Assault (Illinois)

- Child Abuse/Neglect (Illinois) Abuse of Adult with a Disability (Illinois) Developmental Disabilities (Wisconsin and Illinois)

Signature of Patient or Authorized Representative: X _____ Relationship _____

This authorization is effective for _____ months but no longer than 1 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 the Medical Records Department of the source facility. 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 source facility. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. I understand that I am entitled to receive a copy of this completed authorization form.

Prohibition of re-disclosure: This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, and HIV/AIDS tests results, federal requirements (42 CFR Part2) and state requirements (IA Code ch.228&ch.141) (740 Ill. Comp. Stat. § 110/5) (Wis. Code §§252.15(6), 50.30) 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 release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS related testing and or treatment.

Signature of Patient or Authorized Representative

Print Name/Relationship to Patient

Date