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TRINITY REGIONAL MEDICAL CENTER
FORT DODGE, IOWA 50501

Consent For Release of Patient Health Records

Patient Name: _____ Phone: _____ Date of Birth: _____

Address: _____ Social Security Number: _____

City: _____ Medical Record Number: _____

From: _____

To: _____ (Name)

_____ (Address)

_____ (City/State/Zip)

Reason For Release (Check all that apply):

☐ Ongoing care ☐ Legal Reasons ☐ Legal Payments ☐ Patient Asked For

☐ Other: _____

Information To Be Released:

☐ Discharge Report ☐ History and Physical ☐ Emergency Room Report ☐ Consult Report

☐ Pathology Report ☐ Lab, X-Ray, EKG ☐ Surgery Report ☐ Entire Record

☐ Other: _____

Dates of Care: From: _____ To: _____

Specific Release of Health Records Kept Private By State or Federal Law

I give specific consent to release the health records about (check correct box(es)):

☐ Mental Health Treatment ☐ Drug or Alcohol Abuse Treatment ☐ HIV/AIDS test results

_____

*For these health records to be released, you must sign here and also below, and check the record box(es)

I understand and agree that:

- It is my own choice to sign this consent.
- My health care and payment for my healthcare will not change if I do not sign this.
- This consent is good for ____ months, but not more than one year after the date I signed it.
- I may cancel this consent by letting the Medical Records Department know.
- Canceling this consent will not change any actions already taken.
- If the place where these health records go is not a health plan or provider (doctor) the health records released might not be covered by federal privacy rules.
- I have the right to see and get copies of my health records. There may be a charge for the copies. I may see the health records to be given out. I can do this by calling or writing:

  _____
- If I do not give consent to release my health records, they may not be released. The “Notice” of Privacy Practice” can tell me more about my rights with my health care records.
- This is not consent to release my health care records for care not yet given. A new consent will be needed to release health records for any new care given.
- I have been given a copy of this form (Consent for Release of Patient Health Records).

(Patient Label)

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Prohibition of 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 records or by state law for mental health and HIV/AIDS records, federal requirements (42 C.F.R., Part 2) and state requirements (Iowa Codes Chapters 228 and 141.23) prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by law 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 information.

_____ _____ _____

Signature of Patient or Authorized Representative | Relationship to Patient | Date and Time

_____ _____

Witness | Date and Time

IL ONLY: State Law (405 ILCS 5) requires signature of minor if ages 12- 17): _____

For Office Use Only:

☐ Copy of Authorization given to patient and one with record

☐ Request Completed ☐ Request logging into computer

Name/Date/Time of Completion: _____

(Patient Label)