UnityPoint Health
Keokuk

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

(A copy will be provided for patient)

Signature:____ **Date:**______________________

Relationship, if not patient: ________________________ **Witness:** ______________________

Information processed & sent (date/initial):