Form 1989

CONSENT TO RELEASE OF INFORMATION

Hosp. #_____

University of Iowa Hospitals and Clinics (UIHC)
Health Information Management Department; 200 Hawkins Drive, Iowa City, IA 52242
Release of Information Office (Telephone 319-356-1719; FAX 319-356-3079)

Please neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name _____ **Birth Date** _____

By signing this form, I am allowing UIHC to release medical information concerning the above named patient to the person or facility listed below. This information may be shared by: Viewing ___ Verbal ___ Copies ___ CD ___ CareLink _____
(Please note, burning to a CD is only possible when transferring electronic information. Copies of paper documents will be provided on paper.)

_____
Name of Person and/or Institution who will receive information

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates if known): ___Minimum necessary, or specify as follows:
__ Medication list __ Allergy list __ Immunization record ___ Problem List (Pt. Summary list)
__ History and Physical, specify clinic or date_____
__ Discharge summary, specify clinic or date_____
__ Laboratory results, specify type or date_____
__ X-ray and imaging reports, specify type or date_____
__ Consultation reports, specify doctor or clinic _____
__ Test results (e.g. EKG, PFT, etc.), specify type or date _____
__ Billing Information, specify_____
__ Other, specify_____

Please check the reason for release below; and provide a date by which the info is needed: _____

Insurance ____ 2nd opinion _____ Rehab/disability _____ Personal file _____ Moving out of area _____ Legal _____

Other medical care _____ Transferring care _____ **If transferring care,** may we confidentially discuss with you? YES ___ NO___

If yes, please indicate the best time and telephone number to reach you: _____

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address.

UIHC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.

I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).

Substance Abuse_____ Mental Health _____ HIV-related information _____ *Genetic tests/info_____
*Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement will expire two years from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

_____ _____ _____
Signature of Patient or Legal Guardian Printed name Date

_____ _____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, if Not the Patient Witness Signature

UIHC use only: *Upon satisfying this release, date & sign; record on the Release of Information Tracking (ROIT) system and scan the form in to Epic.* ***If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, complete the following as appropriate and then forward to the Release of Information Office, Health Information Management (HIM) Department, 2 SRF.***

Info. sent: _____ _____ Recorded on ROIT System: _____ _____
Name/Department Date Operator Name/Department Date