Form 1989 Hospital #: _____

ADMIN – CONSENT TO RELEASE OF INFORMATION AND RIGHT OF ACCESS REQUEST

University of Iowa Health Care (UI Health Care)

Health Information Management Department, Release of Information Office, 200 Hawkins Dr., HSSB Ste. 100, Iowa City, IA 52242
Telephone: 319-356-1719; Fax: 319-356-3079 or 319-353-7944; Email: him-consentform@uiowa.edu

Patient legal name: _____ **Birth date:** _____

Complete mailing address: _____

List any previous names (maiden, married, legal changes): _____

Send UI Health Care information to:

Name and/or facility: _____

Complete mailing address: _____

Format of information to be released (check)**:**

___ Electronic (circle): CD / USB drive / Email: _____
(Email is not a secure means of communication)

___ Fax: _____ ___ Paper ___ Verbal ___ No records needed at this time, to file only

Information to be released, will be from the previous two years unless specified below (check)**:**

___ Summary of record	___ History and physical	___ Pathology reports
___ Allergy list	___ Immunization record	___ Psychotherapy notes
___ Billing information	___ Laboratory results	___ Radiology images
___ Discharge notes	___ Office visit notes	___ Radiology reports
___ Emergency notes	___ Operative/Procedure reports	___ Test results (EKG, PFT, EMG, etc.)
___ Formerly Corridor OB GYN	___ Formerly Mercy Clinics' records	___ Formerly Mercy Hospital records

___ Other: _____

Date(s): _____ to _____ **and/or Department/Provider:** _____

Reason for release (check)**:**

___ Insurance ___ Legal ___ Medical ___ Personal ___ Rehab or Disability ___ Other: _____

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 information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge: 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 I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address. I have been offered a copy of this authorization. I understand there may be a charge for this information.

UI Health Care 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 **(*check* any category *not* to be released)**.

___ Substance use* ___ Mental health ___ HIV-related information ___ Genetic tests/info**

*Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). **Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This authorization allows release of past and future UI Health Care information and will expire three years from the date of signature, or as indicated (specify number of days or months not to exceed five years) _____ unless cancelled by the patient or person legally authorized. UI Health Care will respond to this request within 30 days of receipt. If additional time is required, you will be notified of the extension. If this consent is completed electronically, it is as valid as if you signed the consent in writing and authorize the release of medical information.

Signature: _____ **Date:** _____ **Time:** _____
(Patient or person legally authorized to consent for patient)

_____ _____
(Printed name of patient or legally authorized person signing) (Relationship to patient or legally authorized person)

UI Health Care use only (check one)**:**

___ No action is needed. Form must be filed under *HIM ROI Authorization* document type.

___ Records need to be released. Form must be forwarded to him-consentform@uiowa.edu or routed to HIM RELEASE OF INFORMATION pool.

Revised: 5-2024