Jefferson County Health Center
2000 S. Main St. Fairfield, IA 52556
Ph# 641- 472 - 4111 Fax# 641- 469 - 4199

RECEIVED	COMPLETED	LOGGED

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or it has expired as described below.

I hereby authorize_____ to disclose the information identified in this Authorization from the health records of

_____
Patient Name and Date of Birth

_____ Telephone#: _____
Address (City, State, Zip)

This information is to be disclosed to Jefferson County Health Center at the following location:

_____
Name of JCHC Facility

_____
Address (City, State, Zip)

JCHC McCreery Cancer Center
Ph# 641-469-4144 Fax# 641-469-4138
JCHC Professional Clinic
Ph# 641-469-4204 Fax# 641-469-4208
JCHC Clinics
Ph# 641-472-4156 Fax# 641-472-9436
Release of Information
Ph# 641-469-4430 Fax# 641-469-4199

Covering the periods of healthcare (Date(s) of Service):

From (date)_____ to (date)_____

For the purpose of: _____
(not required if the disclosure is requested by the patient)

Prefer to acquire records by: Paper ☐ **USB Drive** ☐ **Fax** ☐ Fax#:_____

Information to be released:

Complete health record	☐	History and Physical	☐	Other:	_____
Clinic Notes	☐	Operative Report	☐		_____
Other Tests (EKG, PFT) Specify	☐	Lab, X-ray Report	☐		_____
Billing Information	☐	Consultation Reports	☐		_____
Immunization Record	☐	Medication List	☐		

I understand that this may include information in the following categories unless I specifically deny the release (Initial any category <u>not</u> to be released):

_____HIV/AIDS-related Information _____ Behavioral health service/psychiatric _____Tx-alcohol and/or drug abuse

PATIENT OR GUARDIAN/REPRESENTATIVE ACKNOWLEDGMENT

This authorization is voluntary. I understand that I can revoke this authorization at any time by written notification to the party identified above as the authorized discloser and the revocation will be effective upon such individual's/entity's receipt. I further understand and acknowledge that such revocation will not apply to the authorized discloser's actions taken in reliance on this authorization prior to the effective date. I also acknowledge that disclosure of the above information is associated with the risk that: 1) recipients of this information may re-disclose the information without proper authorization, and 2) once information is disclosed it may no longer be protected by HIPAA.

Covered entities, which include Jefferson County Health Center, the authorized discloser identified above, and other health care facilities/providers, are generally prohibited by HIPAA from requiring an individual to provider an authorization to release protected health information in order to receive health care services. However, when the health care services are 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.

_____ _____
Signature of Patient/Guardian/Legal Representative Date Signed

_____
Relationship if other than Patient

Expiration Date or Event:_____
(Default is two years from date signed unless otherwise indicated above)

R 6/10/24