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 Jefferson County Health Center & Clinics to disclose the information identified on 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:

_____
Name of Institution/ Physician/Spouse/Guardian/legal Representative

_____
Address (City, State, Zip)

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

From (date)_____ to (date)_____

For the purpose of: _____
(not required if the patient is the one initiating this Authorization)

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 Records	☐	Medication List	☐		

I specifically authorize the disclosure of the following information (Any category left blank will not 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 Manager of Health Information Management, Jefferson County Health Center, 2000 South Main Street, Fairfield, IA 52556 and the revocation will be effective upon such individual's receipt. I further understand and acknowledge that such revocation will not apply to Jefferson County Health Center's actions taken in reliance on this Authorization prior to the effective date. I also acknowledge that disclosure of the above health information is associated with the risk that: 1) recipients of this information may 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 and other health care facilities/providers, are generally prohibited by HIPAA from requiring an individual to provide 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

R05/22/24