Date Received _________________

AUTHORIZATION TO RELEASE INFORMATION

Jefferson County Health Center

Health Information Management Department, Release of Information **Phone: 641-469-4430 FAX: 641-469-4199**

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 Jefferson County Health Center to release medical information concerning the above named patient to the person or facility listed below. I would like this information to be shared by: Viewing ____ Copies _____ CD ____Flash Drive____

____

Name of Person and/or Institution who will receive information

____

Complete Mailing Address/Street/P.O. Box **City, State, Zip Code** **Fax Number**

Check the information to be disclosed (*information released from the previous 2 years unless specified below*):

___ Minimum necessary, or specify as follows:

___ Medication list Allergy list_____ Immunization record_____ Medical Diagnosis Problem List____

___ History and Physical, specify clinic or date(s) ____

___ Discharge Summary, specify clinic or date(s) ____

___ Laboratory results, specify type or date(s) ____

___ Imaging reports (X-Ray), specify type or date(s) ____

___ Consultation reports, specify provider, clinic or dates____

___ Other Test results (e.g. EKG, PFT, etc.), specify type or date(s) ________________________________

___ Billing Information, specify date(s) of service____

___ Other, specify____

___ Future record request as needed (no information released)

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the **Director of Health Information Management, Jefferson County Health Center, 2000 South Main Street, Fairfield, IA 52556.** 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.

Jefferson County Health Center 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 ______

*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 agreement allows release of past and future information and will expire 2 (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 Phone Number

_______________________________ _______________________________

Relationship, if Not the Patient **Witness Signature**

*Records released here relate only to the records created @ JCHC. Records that may have been received from other providers or facilities are not included.

Information Released by_______________________________ _______________________

Staff Name **Date**