AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

➔ **NAME:** **MEDICAL RECORD #:**

DATE OF BIRTH: **Phone#:**

➔ **I GENERAL RELEASE: I authorize Gundersen Palmer Lutheran Hospital and Clinics, 112 Jefferson Street, West Union, Iowa 52175 to:**

☐ Release to: ☐ Obtain from:

Address:

The Dates/Types of information to be released is (list specifics – entire record, reports, i.e. labs AND dates)

Reason for Release:

➔ **II. SPECIAL RELEASE:**

I specifically authorize the release of :	☐	**Mental Health records**	**Initial:**
	☐	**Substance Abuse records**	**Initial:**
	☐	**HIV/AIDS information**	**Initial:**

Patient/Representative Signature: **Date:**

Representative Relationship to the Patient: **Witness:**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CRF Part 2).The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Chapter 228 and Chapter 141A of the Iowa Code and other applicable laws.

*******If mental health information is being disclosed, I acknowledge receipt of a copy of this Authorization*******

➔ **ALTERNATIVE CONFIDENTIAL COMMUNICATIONS: (Applies to General and Special Release)**

☐	I authorize transmission of my medical information by FAX for treatment purposes	**Initial:**
☐	I authorize release of information from other facilities that are part of my record	**Initial:**

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the **Health Information Dept. at Gundersen Palmer Lutheran Hospital and Clinics (FAX# 563-422-9520) 112 Jefferson Street, West Union, IA 52175.** I understand that any release, which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand as a patient I have the right to access my records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand that Palmer Lutheran Health Center may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services. This authorization will expire on the following date, event, or condition _____. **If I fail to specify, this authorization will expire in twelve (12) months.** A photocopy of this signed authorization shall be as effective as the original.

➔

Patient/Representative Signature | Date

Representative's Relationship to the Patient | Witness

PLHC use only: ID Verified by:

Date Completed: Initials:

Information to be ☐ mailed ☐faxed ☐picked up

Information has been ☐ mailed ☐faxed ☐picked up

GUNDERSEN PALMER LUTHERAN HOSPITAL AND CLINICS

REQUEST FOR RELEASE OF INFORMATION

Gundersen Palmer Lutheran Hospital and Clinics

GPLHC\Teams\HIM\ROI\2020 AUTHORIZATION TO RELEASE