

CONSENT TO RELEASE OF INFORMATION

University of Iowa Hospitals and Clinics (UIHC)
Health Information Management Department; 200 Hawkins Drive, Iowa City, IA 52242
Release of Information Office (Telephone 319-356-1719; FAX 319-356-3079)

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 UIHC to release medical information concerning the above named patient to the person or facility listed below. This information may be shared by: Viewing ___ Verbal ___ Copies ___ CD ___ CareLink ___
(Please note, burning to a CD is only possible when transferring electronic information. Copies of paper documents will be provided on paper.)

Name of Person and/or Institution who will receive information _____

Complete Mailing Address/Street/P.O. Box _____ City, State, Zip Code _____

Check the information to be disclosed (include dates if known):
___ Medication list ___ Allergy list ___ Immunization record ___ Problem List (Pt. Summary list)
___ History and Physical, specify clinic or date
___ Discharge summary, specify clinic or date
___ Laboratory results, specify type or date
___ X-ray and imaging reports, specify type or date
___ Consultation reports, specify doctor or clinic
___ Test results (e.g. EKG, PFT, etc.), specify type or date
___ Billing Information, specify
___ Other, specify

Please check the reason for release below; and provide a date by which the info is needed: _____

Insurance ___ 2nd opinion ___ Rehab/disability ___ Personal file ___ Moving out of area ___ Legal ___

Other medical care ___ Transferring care ___ If transferring care, may we confidentially discuss with you? YES ___ NO ___

If yes, please indicate the best time and telephone number to reach you: _____

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 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.

UIHC 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 ___

*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 will expire 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 _____

Relationship, if Not the Patient _____ Witness Signature _____

UIHC use only: Upon satisfying this release, date & sign; record on the Release of Information Tracking (ROIT) system and scan the form in to Epic. If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, complete the following as appropriate and then forward to the Release of Information Office, Health Information Management (HIM) Department, 2 SRF.

Info. sent: _____ Recorded on ROIT System: _____
Name/Department Date Operator Name/Department Date