Form 1991

ADMIN - CONSENT TO OBTAIN INFORMATION

Hosp. #_____

University of Iowa Hospitals & Clinics (UIHC)

Please use blue or black ink, neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name: _____ **Birth Date:** _____

List any previous names (maiden, married, legal changes) _____

I, the patient or legal guardian, hereby authorize:

_____
Name of Person and/or Institution

_____
Complete Mailing Address/Street/P.O. Box

_____
City, State, Zip Code

to release medical information concerning the above named patient to:

Dr._____
First Name Last Name

Department of _____
University of Iowa Hospitals & Clinics
200 Hawkins Drive, Iowa City, IA 52242
Department Fax #: _____

Department Phone #: _____

Requested format: ____ Fax ____ CD ____ Copies

Check the information to be disclosed (include dates if known): _____ Minimum necessary, or specify as follows:

__ Medication list _____ Allergy list _____ Immunization record
__ History and physical, specify area or date_____
__ Discharge summary, specify area or date_____
__ Laboratory results, specify type or date_____
__ Radiology reports, specify type or date_____
__ Radiology images on CD, specify type or date_____
__ Consultation reports, specify area or date_____
__ 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: _____

Moving out of area _____ Rehab/disability _____ Insurance _____ 2nd opinion _____ Legal _____

Personal file* _____ Medical care _____ Transferring care _____ Other (specify) _____

*Payment may be required (check only).

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. I have been offered a copy of this authorization.

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***_____

****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 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: Form sent _____ by _____ _____
Date Name Department

Revised: 12-2018 Original: To be Sent Copy: Patient