Form 1991 Hospital #: _____

ADMIN - CONSENT TO OBTAIN INFORMATION

University of Iowa Health Care (UI Health Care)

Patient legal name: _____ **Birth date:** _____

Complete mailing address: _____

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

Obtain information from:

Name and/or facility: _____

Complete mailing address: _____

Send information to:

Facility & complete mailing address: University of Iowa Health Care, 200 Hawkins Dr., HSSB Ste. 100, Iowa City, IA 52242

Format of information to be released (check)**:**

___ Electronic (circle): CD / USB drive / Email: him-external-fax@healthcare.uiowa.edu
(Email is not a secure means of communication)

___ Fax: 319-356-3949 ___ Paper

Information to be released, from the previous two years unless specified below (check)**:**

___ Summary of record	___ History and physical	___ Pathology reports
___ Allergy list	___ Immunization record	___ Psychotherapy notes
___ Billing information	___ Laboratory results	___ Radiology images
___ Discharge notes	___ Office visit notes	___ Radiology reports
___ Emergency notes	___ Operative/Procedure reports	___ Test results (EKG, PFT, EMG, etc.)

___ Other: _____

Date(s): _____ to _____ **and/or Department/Provider:** _____

Reason for release (check)**:**

___ Insurance ___ Legal ___ Medical ___ Personal ___ Rehab or Disability ___ Other: _____

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 information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge: 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 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.

UI Health Care 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 **(*check* any category *not* to be released)**.

___ Substance use* ___ 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 authorization allows release of past and future UI Health Care information and will expire three years from the date of signature, or as indicated (specify number of days or months not to exceed five years) _____ unless cancelled by the patient or person legally authorized. If this consent is completed electronically, it is as valid as if you signed the consent in writing and authorize the release of medical information.

Signature: _____ **Date:** _____ **Time:** _____
(Patient or person legally authorized to consent for patient)

_____ _____
(Printed name of patient or legally authorized person signing) (Relationship to patient or legally authorized person)

UI Health Care use only: ___ Initial if form has been processed.

Revised: 5-2024