



CONSENT TO RELEASE OF INFORMATION
University of Iowa Diagnostic Laboratories (UIDL)
 UIDL Billing Account # _____

University of Iowa Diagnostic Laboratories (UIDL), 200 Hawkins Dr. 5231 RCP, Iowa City, IA 52242
 Telephone: 319-353-7958; Fax: 319-356-0729
 Email: UIDL Reference Billing Department uidlreferencebillingdepartment@healthcare.uiowa.edu

This form does not replace any other Consent to Release of Information Form that may or may not be on file within University of Iowa Hospitals and Clinics. This form is for release of information only as it pertains to the billing of reference laboratory services provided to the patient through the UIDL, as ordered by the patient's non-UIHC physician.

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

Patient's Legal Name (Last, First): _____ **Birth Date:** _____
List any previous names (maiden, married, legal changes) _____

Billing Address as shown on a recent UIDL patient statement of charges

By signing this form, I am allowing UIDL to release medical information concerning the above-named patient to the person or facility listed below.

Information may be shared by: ___ Verbal ___ Copies
 (Copies of paper documents will be provided on paper.)

Name of Person who will receive information Fax # (If urgent) (Last) _____ (First) _____
 Name Institution who will receive information Fax # (If urgent) _____
 Complete Mailing Address/Street/P.O. Box City, State, Zip Code _____

Check the information to be disclosed (include dates if known):

Billing information, specify _____

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

___ Account Payment to UIDL for reference laboratory services performed
 ___ Other (specify) _____

This consent is voluntary. If I cancel this consent later, I must send written notification to University of Iowa Diagnostic Laboratories (UIDL) 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 University of Iowa Diagnostic Laboratories (UIDL) at the above address. I have been offered a copy of this authorization.

UIDL 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 (if different than listed above) _____

Relationship, if Not the Patient _____ Witness Signature _____

UIDL use only: Upon satisfying this release, date & sign; scan the form into the UIDL Billing System.

Information sent by: UIDL Staff Name _____ Date _____