

CONSENT TO RELEASE OF INFORMATION
University of Iowa Hospitals and Clinics (UIHC)

Hosp. #: _____

Please PRINT (except signature) and provide complete information in each section.

Patient Name _____ Birth Date _____ Soc. Sec. # _____

I understand by signing this form, I am allowing UIHC to release medical information concerning the above named patient to:

Name of Person and/or Institution _____

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

- Check the information to be disclosed (include dates where indicated):
___ Medication list ___ Allergy list ___ Immunization record ___ Problem List (Pt. Summary list)
___ Most recent history and physical or specific date
___ Most recent discharge summary or specific date
___ Laboratory results, specify type or date
___ X-ray and imaging reports, specify type or date
___ Consultation reports (specify doctor or clinic)
___ Test results (i.e. EKG, PFT, etc.), specify type and date
___ Billing Information, specify
___ Other, specify

As per my request, the reason for release of information is: ___medical care ___legal ___insurance ___other (specify) _____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to the Director of Health Information Management, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, IA 52242. 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 that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address.

I understand that UIHC 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.

I understand that the information to be released 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 _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____.

Signature of Patient or Legal Guardian _____ Date _____

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

Relationship, if Not the Patient _____ Witness Signature _____

UIHC use only: Upon satisfying release, date & sign, record on the Release of Information Tracking (ROIT) system and file the original of this form in the back of the medical record. If unable to enter this information release on the ROIT system, forward to the Release of Information Office, HIM, 2 SRF.

Info. sent: _____ Name/Department _____ Date _____

Recorded on ROIT System: _____ Operator Name/Department _____ Date _____