

**Authorization for Release of Medical Information**

**INSTRUCTIONS:** Make sure all blanks are filled in, failure to do so may prevent or delay release of information.

**PATIENT:** Name: \_\_\_\_\_

**IDENTIFICATION:** Date of Birth: \_\_\_\_\_

Parents/Previous name(s): \_\_\_\_\_

**PROVIDER:** Name: \_\_\_\_\_

(Who is releasing the information sent) Address: \_\_\_\_\_

- INFORMATION:**
- |   |  |
|---|--|
| <input type="checkbox"/> Complete Records _____         | <input type="checkbox"/> Immunization Record _____     |
| <input type="checkbox"/> Lab Data, Date _____           | <input type="checkbox"/> X-ray Data, Date _____        |
| <input type="checkbox"/> EKG, Date _____                | <input type="checkbox"/> Discharge Summary, Date _____ |
| <input type="checkbox"/> History & Physical, Date _____ | <input type="checkbox"/> Other _____                   |

- PURPOSE:**
- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Transferring Medical Care | <input type="checkbox"/> Moving      |
| <input type="checkbox"/> Insurance Coverage        | <input type="checkbox"/> Other _____ |

**INFORMATION SENT TO:** Name: \_\_\_\_\_

Address: \_\_\_\_\_

MCI will not condition treatment on your signing this authorization, unless: (1) you are receiving research-related treatment; or (2) the only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

**Specific Authorization for Release of Information Protected by State or Federal Law**

I specifically authorize the release of data and information relating to:

- |   |   |
|---|---|
| <input type="checkbox"/> Substance abuse (alcohol/drug)                 | <input type="checkbox"/> Mental Health (includes psychological testing) |
| <input type="checkbox"/> HIV-related information (AIDS-related testing) |   |

The authorization is **effective for one year** from the date on which it was signed. I understand that I may **revoke** this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Mercy Clinics, Inc. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Mercy Clinics, Inc. The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the MCI Notice of Privacy Practices.

Signature of Patient or Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient, If not signed by Patient: \_\_\_\_\_ Witness: \_\_\_\_\_

Date Information Sent: \_\_\_\_\_ Person Releasing Records: \_\_\_\_\_ Physician: \_\_\_\_\_

**PROHIBITION OF REDISCLOSURE**

Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42.C.F.R. Part 2) and state requirements (Iowa Code ch. 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. I understand all other information used and/or disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

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