IOWA DIGESTIVE DISEASE CENTER

Iowa Endoscopy Center

Authorization to Release Protected Health Information to a Third Party

Form content retained in medical record.

Instructions: This form is to be used by a patient or legal representative to authorize the release of information to a third party (other than a family member or friend) such as an insurance company, employer, or for legal purposes, etc. Print clearly; each section needs to be completed to be valid.

1. Additional Patient Information

Patient Name (*first, middle, last)* and any previous or maiden name	☐ Check this box if patient is deceased, & provide documentation of death.
Patient Address *(Street, City, State, ZIP Code)*	
Date of Birth	Daytime Phone

2. Release Purpose

Check appropriate box or write in other purpose.

☐ Continuing care ☐ Disability ☐ Forms completion ☐ Insurance ☐ Legal ☐ Workers' compensation

☐ Other, specify_____

3. Release Information FROM

Check one box and complete if applicable.

☐ **Iowa Digestive Disease Center**
Includes Iowa Endoscopy Center

☐ **Other,** specify organization, department, or individual (complete each line below)

Name _____

Street_____

City_____

State_____ZIP Code_____

Phone_____

4. Release/Send Information TO

Check one box and complete each line for box checked.

☐ **Iowa Digestive Disease Center**

Attn: Medical Records Fax: 515-288-8335

☐ **Other,** specify organization, department, or individual (complete each line below)

Name _____

Street_____

City_____

State_____ZIP Code_____

Phone_____

This authorization will expire in 1 year from date of signature unless another date is specified below:

☐ **By checking this box** I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

☐ **By checking this box** I also authorize the release of records for future visits or stays after the date of my signature until this authorization expires or is revoked.

5. Delivery of Information

Preferred Method ☐ CD/ DVD ☐ Written (paper copy) ☐ Verbal only	Date Information Needed by *(mm-dd-yyyy)*

CD/ DVD information will be mailed unless an alternate method is checked.

☐ Iowa Digestive Disease Center Patient Portal

☐ Email to the following address (Email will be sent via secured message): _____

☐ Fax to: _____

☐ Other, specify_____

☐ Pick-up at Iowa Digestive Disease (check box location): ☐ Clive ☐ Ankeny ☐ Other Location:_____

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6. Records or Reports to Be Released

Timeframe to be released

Date(s)_____ *(mm-dd-yyyy)* or Year(s)_____ *(yyyy)*

Document/Note(s) (check all that apply)

- ☐ Behavioral health/ Mental/ Psychological notes
- ☐ Operative/Procedure notes
- ☐ Therapy notes (physical, occupational, speech)
- ☐ Emergency department/Urgent care notes
- ☐ Provider notes
- ☐ Other, specify _____

I understand the information to be released may include behavior and/or mental health care, and HIV test results.

Additional Records (Check all that apply)

- ☐ Allergy List
- ☐ Immunizations
- ☐ Medication List
- ☐ HIV Lab test results
- ☐ Genetic testing
- ☐ Pathology reports
- ☐ EKG(s)/ Cardio/Echo
- ☐ Laboratory Results
- ☐ Radiology Report(s)
- ☐ Billing information

Substance Abuse and Addiction Treatment Records (Check all that apply)

- ☐ Assessment/ Evaluation
- ☐ History and physical exam
- ☐ Multidisciplinary notes
- ☐ Treatment/ Discharge summary
- ☐ Treatment plans
- ☐ Other: Specify_____

Other, specify if applicable _____

7. Signature and Date The patient or legal representative must sign and date this authorization.

- This authorization may be revoked at any time by providing a written notice of revocation to the Health Information Management Services (HIMS) Release of Information (ROI) department at the facility releasing the information, except to the extent that the Providers have already taken action in reliance on it.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- I understand that Iowa Digestive Disease Center and Iowa Endoscopy Center will not condition treatment on whether I sign this authorization.
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have the right to inspect and receive a copy of the material to be disclosed.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Signature (required)	**Date** (required) *(mm-dd-yyyy)*

Printed Name of person signing **(if not patient)** *(First, Middle, Last)*

Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)

☐ Parent ☐ Stepparent ☐ Legal guardian ☐ Foster parent ☐ Health care power of attorney/agent ☐ Other_____

HIMS* Release of Information Contact Information

Clive- Main Office	**Ankeny- Ankeny Medical Park**	**Indianola- Mercy**	**Norwalk- Unity Point**	**Southglenn - Unity Point**
1378 NW 124th Street Clive, IA 50325 **Phone : (515) 288-6097** **Fax: (515) 288-8335**	3625 N. Ankeny Blvd., Suite D Ankeny, Iowa 50023	2006 N 4th Street Indianola, IA 50125	801 Colonial Circle Norwalk, IA 50211	6520 SE 14th Street Des Moines, IA 50320