REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Health Information Department
1600 1st Street East Independence, IA 50644
(319) 332−0999 ext 1051 Office Hours Mon − Fri 7:00 to 4:00

PATIENT IDENTIFICATION:
Name _____
Date of Birth_____ Soc. Sec._____ Medical Record #: _____
Address _____

PROVIDER:
(Who is releasing the information)
Name _____
Address _____

REQUESTOR:
(Where do you want the information sent)
Name _____
Address _____

PURPOSE OF RELEASE: (CHECK ALL THAT APPLY)
❒ Continued Care ❒ Legal ❒ Insurance ❒ Personal Use ❒ Other _____

INFORMATION REQUESTED:
For date(s) of service: _____
❒ Discharge summary
❒ ER Department Record
❒ Lab Data
❒ Physical Therapy Reports
❒ Entire Record
❒ History and Physical
❒ Operative Report
❒ X−ray Report ❒ CD
❒ Consultation Reports
❒ Other _____

FORMAT: ❒ CD ❒ Paper Copy

****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY STATE OR FEDERAL LAW****

Initial any category to BE released:
_____ Acquired immunodeficiency Syndrome (AIDS) or human immunodeficiency virus (HIV)
_____ Alcohol and drug abuse treatment
_____ Behavioral or mental health services

I understand that I may cancel (revoke) this authorization at any time by sending a written notice to Buchanan County Health Center's Health Information (medical records) department and that my cancellation will take effect when the written notice is received and it will not apply to information that has already been released in response to this authorization. This authorization will automatically expire 365 days from the date of signature except as specified. (Specify expiration date, event, or condition: _____)

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re−disclosed and no longer protected by federal privacy regulations unless otherwise prohibited from re−disclosure under other federal and/or state laws or regulations.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ DATE_____

RELATIONSHIP TO THE PATIENT, IF NOT SIGNED BY PATIENT_____

DATE INFORMATION SENT _____

Printed : 3−21−2016