AUTHORIZATION FOR DISCLOSURE OF PHI

Please complete this form in its entirety. This authorization is not valid and the Covered Entity will not release your PHI unless the form is completed in its entirety. A copy of the signed authorization will be provided to you.

THE FOLLOWING PERSON(S) OR ENTITY:
Name of Person(s) or Entity: _____

Address of Person(s) or Entity: _____
_____

SHALL DISCLOSE THE FOLLOWING INFORMATION FROM THE HEALTH RECORDS OF:
Name: (First/Middle/Last) _____
Address: (Street/City/ State/Zip code) _____
Birth date: (Month/Day/Year) _____Social Security #: _____
Telephone Number: (Home) _____ (Work) _____

THIS INFORMATION SHALL BE DISCLOSED TO THE FOLLOWING PERSON(S) OR ENTITY:
Name of Person(s) or Entity:_____
Address of Person(s) or Entity:_____

THE INFORMATION DISCLOSED SHALL COVER HEALTH CARE FOR THE FOLLOWING PERIOD(S) OF TIME:
From: (month/date/year) _____To: (month/date/year) _____
From: (month/date/year) _____To: (month/date/year) _____

THE INFORMATION SHALL BE DISCLOSED FOR THE FOLLOWING PURPOSE(S):
(Not required if the disclosure is requested by the Individual)
_____
_____

THE FOLLOWING INFORMATION SHALL BE RELEASED:
_____
_____

I UNDERSTAND THAT THIS WILL INCLUDE INFORMATION RELATING TO: (Initial, if applicable)
_____ Acquired Immunodeficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV).

_____ Behavioral/Mental Health service/psychiatric care. (Note: you have the right to inspect the disclosed mental health information at any time)

_____ Treatment for alcohol and/or drug abuse.

AFFIRMATION OF AUTHORIZATION:

I give the person(s) or entity named above permission to disclose only the information I have identified on this authorization form to the person(s) or entity I have named and only for the purposes I have identified. I understand: (*Please initial after reading each statement*)

_____ This authorization is valid for one year from the date I sign unless revoked prior to that date.

_____ I may refuse to sign this authorization (A refusal to sign the authorization may affect payment for or eligibility for benefits).

_____ I may revoke this authorization in writing at any time. (A revocation of this authorization may affect payment for or eligibility for benefits). This authorization cannot be revoked to the extent that the Covered Entity has taken action in reliance on the authorization or the authorization was a condition of obtaining insurance coverage.

_____ I understand that this information may be re-disclosed by the person(s) or entity receiving the information and no longer protected by 45 C.F.R. §164.508.

I may access my PHI by following the procedure outlined in the Notice of Privacy Practices.

_____

Signature of the Individual Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

_____

Signature of personal representative Date

_____

Legal authority of personal representative

The following statement pertains to any disclosure or redisclosure of substance abuse, alcohol or drug treatment information, mental health information, or HIV/AIDS-related information:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2), or Iowa confidentiality rules (Iowa Code §228, Iowa Code §141A). The law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Iowa Code §228, Iowa Code §141A or 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the records protected by Federal confidentiality rules (42 CFR Part 2) to criminally investigate or prosecute any alcohol or drug abuse patient.

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE PATIENT OR PATIENT'S REPRESENTATIVE. NOTE: PHOTOCOPY OF THIS SIGNED AUTHORIZATION SHALL BE AS EFFECTIVE AS THE ORIGINAL.