Form 1989

CONSENT TO RELEASE OF INFORMATION

Hosp. #_____

University of Iowa Hospitals & Clinics (UIHC)

Health Information Management Department, Release of Information Office, 200 Hawkins Dr., Iowa City, IA 52242
Telephone: 319-356-1719; Fax: 319-356-3079 or 319-353-7944; Email: him-consentform@uiowa.edu

Please use blue or black ink, neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name: _____ **Birth Date:** _____

List any previous names (maiden, married, legal changes) _____

By signing this form, I am allowing UIHC to release medical information concerning the above named patient to the person or facility listed below. Information may be shared by: _x__Verbal __x_Copies __x_CD __x_CareLink ___MyChart ___ To File Only

(Please note, burning to a CD is only possible when transferring electronic information. Copies of paper documents will be provided on paper.)

Neurology& Sleep Clinic, PLC — Name of Person and/or Institution who will receive information

319-754-4412 — Fax # (If urgent)

1225 South Gear Ave. STE 153 — Complete Mailing Address/Street/P.O. Box

West Burlington, IA 52655 — City, State, Zip Code

Check the information to be disclosed (include dates if known): _____ Minimum necessary, or specify as follows:

__x__ Medication list ____x__ Allergy list ____xx__ Immunization record
__x__ History and physical, specify area or date _____
__x__ Discharge summary, specify area or date _____
__x__ Laboratory results, specify type or date _____
__x__ Radiology reports, specify type or date _____
__x__ Radiology images on CD, specify type or date _____
__x__ Consultation reports, specify area or date _____
__x__ Test results (e.g. EKG, PFT, etc.), specify type or date _____
__ Billing information, specify _____
__ Other, specify _____

Please check the reason for release below; and provide a date by which the info is needed: _____

Moving out of area _____ Rehab/disability _____ Insurance _____ 2nd opinion _____ Legal _____

Personal file* _____ Medical care _____ Transferring care _____ Other (specify) _____

*Payment may be required (check only).

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) 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 have been offered a copy of this authorization.

UIHC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services. I understand that the information may be released electronically, and 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 _____ Genetic tests/info***_____

****Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). *****Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement allows release of past and future information and will expire two years from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

_____ Signature of Patient or Legal Guardian

_____ Printed name

_____ Date

_____ Complete Mailing Address/Street/P.O. Box

_____ City, State, Zip Code

_____ Relationship, if Not the Patient

_____ Witness Signature

UIHC use only: *Upon satisfying this release, date & sign; record on the Release of Information Tracking (ROIT) system and scan the form in to Epic.* ***If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, complete the following as appropriate and then forward to the Release of Information Office, Health Information Management (HIM) Department, at address above.***

Information sent by: _____ Name

_____ Department

_____ Date