VAN DIEST MEDICAL CENTER
An Affiliate of MERCYONE

2350 Hospital Drive
P.O. Box 430
Webster City, IA 50595
P. 515-832-7726
F. 515-832-9494

Van Diest Family Health Clinic – Stratford
817 Shakespeare Ave.
Stratford, IA 50249
P. 515-838-2100
F. 515-838-2193

Van Diest Family Health Clinic – Jewell
731 Main St.
Jewell, IA 50130
P. 515-827-6175
F. 515-827-6189

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:		**DATE OF BIRTH:**	
PHONE NUMBER:		**MR or VISIT NUMBER:**	
STREET ADDRESS:		**CITY, STATE ZIP**	

INFORMATION BEING SENT TO/FROM (CHECK ONLY ONE) – Please be as specific as possible to ensure records are retrieved/sent timely. If there is a specific doctor at another facility, please list their name.

☐ Information to be released **FROM** Van Diest Medical Center **TO** the facility or individual specified below:

Name of facility or individual
Van Diest Medical Center Primary Care Provider
Address
Phone

☐ Information to be released **TO** Van Diest Medical Center **FROM** the facility or individual specified below:

Name of facility or individual
Address
Phone

PURPOSE FOR DISCLOSURE

Select at least one reason:

☐ Treatment/Continuity of Care ☐ Insurance Claim ☐ Personal Use
☐ Transfer of Care ☐ Legal Review/Purposes ☐ Other: _____

TYPE OF INFORMATION REQUESTED

Please note: There may be a charge associated with copies of the Medical Record

For Date(s) of service: _____

☐ Clinic Notes ☐ Phys./Occ./Sp. Therapy ☐ Radiology Reports ☐ Billing Information
☐ Hospital Notes ☐ Laboratory Reports ☐ Radiology Images ☐ Other: _____
☐ Medications/Allergies ☐ Immunization Records ☐ EKG/Cardio/Echo _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY STATE OR FEDERAL LAW Pertains to:
Behavioral Health Therapy visits with LISW and/or Senior Life Solutions

Initial here for any category to BE released: _____

☐ AIDS-Related Information, Diagnosis, and Test Results
☐ Substance Abuse (Drug or Alcohol) Information/Chemical dependency
☐ Mental Health Information
☐ Genetic Information

**** Federal and/or State law specifically requires that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:**
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2.) The Federal rules prohibit 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 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 information to criminally investigate or prosecute any alcohol or drug abuse patient.

DISCLOSURE:

I understand that I may cancel (revoke) this authorization at any time by sending a written notice to Van Diest Medical Center's HIM/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 <u>one year</u> 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 AND DATE

If this release is signed by a representative on behalf of the patient, complete the following:

Patient's Signature: _____ Date: _____

OR:

Representative's Name: _____ Date: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

Please do not write in this section

Request Received Date: _____ Records Released Date: _____

Released By: _____ Comments/ID: _____