

CONSENT TO RELEASE OF INFORMATION

University of Iowa Hospitals and Clinics (UIHC)

Please PRINT (except signature) and provide complete information in each section.

Patient's Legal Name _____ Birth Date _____

By signing this form, I am allowing UIHC to release medical information via: copies _____ viewing _____ verbal _____ concerning the above named patient to the following:

Name of Person and/or Institution

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

- Check the information to be disclosed (include dates if known):** _____ Minimum necessary, or specify as follows:
- Medication list Allergy list Immunization record Problem List (Pt. Summary list)
 - History and Physical, specify clinic or date _____
 - Discharge summary, specify clinic or date _____
 - Laboratory results, specify type or date _____
 - X-ray and imaging reports, specify type or date _____
 - Consultation reports, specify doctor or clinic _____
 - Test results (e.g. EKG, PFT, etc.), specify type or date _____
 - Billing Information, specify _____
 - Other, specify _____

Please indicate the reason for release, and provide a date by which the info is needed: _____

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

Other medical care _____ Transferring care _____ **If transferring care, may we confidentially discuss with you?** YES _____ NO _____

If yes, please indicate the best time and telephone number to reach you: _____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Director of Health Information Management, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, IA 52242. 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.

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 _____

*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 will expire one year 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 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, 2 SRF.

Info. sent: _____ Name/Department Date Recorded on ROIT System: _____ Operator Name/Department Date