

CONSENT TO RELEASE OF INFORMATION
University of Iowa Hospitals and Clinics (UIHC)

Hosp. #: \_\_\_\_\_

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

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

I understand by signing this form, I am allowing UIHC to release medical information concerning the above named patient to:

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 where indicated):
\_\_\_ Medication list \_\_\_ Allergy list \_\_\_ Immunization record \_\_\_ Problem List (Pt. Summary list)
\_\_\_ Most recent history and physical or specific date
\_\_\_ Most recent discharge summary or specific date
\_\_\_ Laboratory results, specify type or date
\_\_\_ X-ray and imaging reports, specify type or date
\_\_\_ Consultation reports (specify doctor or clinic)
\_\_\_ Test results ( i.e. EKG, PFT, etc.), specify type and date
\_\_\_ Billing Information, specify
\_\_\_ Other, specify

As per my request, the reason for release of information is: \_\_\_ moving out of area \_\_\_ transferring care \_\_\_ 2nd opinion
\_\_\_ other medical care \_\_\_ personal file \_\_\_ legal \_\_\_ insurance \_\_\_ other (specify)

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to the Director of Health Information Management, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, IA 52242. I understand that any release which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and 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 understand that UIHC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that the information to be released 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 \_\_\_\_\_

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) \_\_\_\_\_.

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, forward to the Release of Information Office, Health Information Management (HIM) Department, 2 SRF, for processing.

Info. sent: \_\_\_\_\_ Name/Department \_\_\_\_\_ Date \_\_\_\_\_

Recorded on ROIT System: \_\_\_\_\_ Operator Name/Department \_\_\_\_\_ Date \_\_\_\_\_