**MANNING REGIONAL HEALTHCARE CENTER/MANNING FAMILY RECOVERY CENTER**

MANNING, IOWA 51455

**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION**

**PATIENT INFORMATION:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS NAME(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MED REC#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS/CITY/STATE/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DAYTIME PHONE NUMBER(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if the person(s) and or organizations(s) listed below are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standard, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards, and my health information may be re-disclosed without obtaining my authorization.

I understand that I may revoke this authorization at any time by notifying Manning Regional Healthcare Center in writing, but if I do, it will not have any effect on the actions they took before they received the revocation. Unless expressly revoked at an earlier time, this authorization will automatically expire one year from date of signature or on \_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_, or as specified ~(specific condition as listed here): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Any refusal to sign this form will not affect my ability to obtain treatment, payment, or my eligibility for benefits. I may request to inspect or copy the health information to be used or disclosed. This release is not valid if it does not contain the patient signature.

**RELEASE INFORMATION FROM: SEND INFORMATION TO:** Upcoming appt. date \_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME: \_\_\_MRHC, ATTN: MEDICAL RECORDS\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS: \_1550 6th Street; Manning, IA 51455\_\_\_\_\_\_\_\_\_\_\_\_

PH#/FAX#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH#/FAX#:\_Ph 712-655-2072/Fax 712-655-8305\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request the records be copied and forwarded via: \_\_mail \_\_fax \_\_pick up \_\_electronic transfer \_\_no preference.

I understand this does not include any correspondence/records generated from non-MRHC/MFRC facilities. Those will need to be obtained from that particular facility.

**MEDICAL INFORMATION TO BE RELEASED:** Approximate dates of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Office Notes (this will be limited to 2 years of information including lab and x-ray, unless otherwise specified)

\_\_Lab \_\_Pathology \_\_X-Ray Reports \_\_X-Ray films/images \_\_OB Records

\_\_H&P \_\_Dr Orders \_\_Dr progress notes \_\_Consultations \_\_Operative Reports

\_\_Physical Therapy \_\_Immunizations \_\_EKG/Cardiac Testing \_\_Nurse notes \_\_Billing information

\_\_Other-Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:**

I specifically authorize the release of data and information relating to: (NOTE~ You MUST mark ‘yes’ or ‘no’)

\_\_YES \_\_NO Substance Abuse (alcohol/drug abuse) records

\_\_YES \_\_NO Infectious disease records including HIV/AIDS and sexually transmitted disease testing

\_\_YES \_\_NO Mental Health/Depression (includes Psychological testing) records

\_\_YES \_\_NO Genetic testing/Family history information

**I AM REQUESTING THIS INFORMATION TO BE RELEASED FOR THE FOLLOWING PURPOSE:**

\_\_Specialist Involvement \_\_Transfer of Care \_\_Worker’s Comp \_\_Insurance \_\_Disability

\_\_Legal \_\_Moving \_\_2nd Opinion \_\_Other-Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF PATIENT OR REPRESENTATIVE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Legal documentation is required supporting his/her authority to act on a patient’s behalf.

WITNESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROHIBITION ON REDISCLOSURE:** This form does not authorize redisclosure of protected health information beyond the limits of this consent. Where information has been disclosed from records protected by federal law and by state law for mental health records, FEDERAL REQUIREMENTS (42 C.F.R. Part 2) and STATE REQUIREMENTS (Iowa Code Ch.228) PROHIBIT FURTHER DISCLOSURE WITHOUT THE SPECIFIED WRITTEN AUTHORIZATION OF THE PATIENT, OR OTHERWISE PERMITTED BY SUCH LAW SUFFICIENT FOR THESE PURPOSES. Civil and/or criminal penalties may attach for any unauthorized disclosure of alcohol/drug or mental health information. NOTE REGARDING CRIMINAL JUSTICE REFERRALS: If the patient’s treatment is court-ordered and this authorization is for disclosure to criminal justice officials, 1) this authorization will automatically expire upon notice O.T. the hospital of final disposition of the patient’s court case, and 2) information provided under this consent may be used by the recipient only to carry out official duties with regard to court proceedings for which the authorization was used.

Request Sent By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Sent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Revised 02/25/2020