Provider _____

AUTHORIZATION TO OBTAIN, RELEASE, AND REDISCLOSE
CONFIDENTIAL HEALTH INFORMATION

RIVER HILLS COMMUNITY HEALTH CENTER OTTUMWA CLINIC

PHONE 641-684-6896 201 S. Market St., PO Box 458, Ottumwa, IA 52501 FAX 641-682-0484 or 641-684-3080

Please neatly PRINT (except signature) in BLUE or BLACK INK and provide complete information in each section.

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

PROVIDER: *(Who is releasing the information)*
Name _____ Phone # _____
Address _____
Complete mailing address/Street/P.O. Box City, State, Zip Code

REQUESTOR: *(Where you want the information sent)*
Name _____ Phone # _____
Address _____
Complete mailing address/Street/P.O. Box City, State, Zip Code

Please check below the type of information you want released and the reason for the release of information.

INFORMATION REQUESTED
☐ All Health Care Records from _____/_____/_____ to _____/_____/_____
☐ Medical ☐ Pediatrics ☐ GYN ☐ Dental
☐ History & Physical ☐ Immunization Record ☐ Discharge Summaries
☐ Medications ☐ Lab Reports ☐ X-Ray ☐ Communication for_____

PURPOSE OF RELEASE
☐ Request of Patient/Legal Representative ☐ Transferring Medical Care
☐ Other_____

This authorization to release information is voluntary. I know I do not have to complete this form in order to receive treatment. By signing this form I am allowing River Hills CHC to release my confidential health information to the person or facility listed. I 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 know I have the right to inspect the information to be disclosed, unless restricted by law, upon the proper notification to and under conditions established by River Hills CHC. I understand the information may be released orally or via fax, mail or electronically.

_____ _____
Signature of Patient/Personal Representative **Date**

_____
Relationship, if not the patient

Additional Iowa and/or federal confidentiality protections are provided to Mental Health, Alcohol and Drug Abuse Treatment, HIV/AIDS and certain other confidential information. I understand that I have the right to prohibit redisclosure of this information and that further disclosure or redisclosure of these records may not be made without my specific written consent unless otherwise permitted by law. My signature below authorizes the release of the records identified herein.

AUTHORIZING INITIALS
____Alcohol
____Substance Abuse
____Mental Health
____Genetic Testing
____HIV/AIDS Information

_____
Signature of Patient/Personal Representative

_____ _____
Relationship, if not the patient **Date**

Prohibition of Redisclosure

Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following: 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 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.

This authorization will expire one-year from the date of signature, or as indicated _____. I understand that I may revoke this authorization at any time. If I cancel this authorization, I must send written notification to River Hills CHC, 1015 N 18th St, Ste C, PO Box 248, IA 52544. I understand that information may have already been released prior to the cancellation and that action would not be considered a breach of confidentiality. I understand my healthcare and payment for my healthcare will not be affected by this authorization. By signing this form, I authorize the disclosure and redisclosure described above. (Date Revised 3/13/18)

Staff initials_____