

Authorization for Release of Healthcare Information

Return form to:
shcreco@iastate.edu

Patient Information:

Patient Name (Last, First, Middle, Maiden):	
Current Address (including City, State, Zip):	
University ID#	Date of Birth (MM/DD/YYYY)
Phone #:	Email Address:

I hereby authorize written and/or verbal RELEASE of my healthcare information as indicated:

Release Information FROM		Release Information TO	
Name:		Name:	
Address:		Address:	
City, State ZIP:		City, State Zip:	
Phone:	Fax:	Phone:	Fax:
Email:		Email:	

Please send my records by: Mail Fax Secure Email

INFORMATION REQUESTED:	REASON FOR RELEASE:
<input type="checkbox"/> Immunizations/titers/TB testing results: <input type="checkbox"/> All <input type="checkbox"/> Specific Immunizations:	<input type="checkbox"/> Continuing/transfer of care
<input type="checkbox"/> X-ray dates/condition: <input type="checkbox"/> X-ray report (no images) <input type="checkbox"/> X-ray image (CD)	<input type="checkbox"/> Legal/attorney
<input type="checkbox"/> Lab(s) dates/condition	<input type="checkbox"/> Insurance purposes
<input type="checkbox"/> Billing information dates:	<input type="checkbox"/> Personal use
<input type="checkbox"/> Physical Therapy dates/condition:	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Other (specify):	<input type="checkbox"/> Upcoming Appt:
<input type="checkbox"/> My complete medical records from/to the following date(s): OR about the following condition(s): <input type="checkbox"/> include records from outside medical providers/clinics/hospitals	

PLEASE READ: ADDITIONAL AUTHORIZATION REQUIRED: I authorize, with my initials, the release of the following types of records:

Substance Abuse _____ Mental Health _____ HIV/AIDS _____ Sexual Assault Exam information _____

NOTE: Patients who believe these record types do not pertain to them may still choose to initial above to expedite the record release process. If you choose not to initial, your record must be reviewed in detail to determine if these record types are present. This review and redaction process can take up to 30 business days. Pursuant to Iowa law, TSHC may disclose substance abuse and mental health records (but not HIV/AIDS or sexual assault exam information) to another healthcare provider for continuation or transfer of care without your express consent if not otherwise restricted by federal law or regulation, or as otherwise defined in our Notice of Privacy Practice (NPP).

I have read the above and have initialed by the types of records I authorize to include with this ROI _____ (initial here)

Further, I agree and understand:

1. This authorization may be revoked at any time by notifying TSHC in writing except to the extent that action has been taken in reliance on it.
2. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release.
3. My refusal to sign, or revocation of, this authorization will not affect my ability to obtain healthcare services from TSHC.
4. The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy rules.
5. There may be a fee associated with the copying of records.
6. In accordance with federal law, TSHC may take up to 30 days to process this request and release my records.
7. This agreement will expire one year from the date of signature below, unless previously revoked or otherwise indicated here: _____

Patient's Printed Name

Today's Date (MM/DD/YYYY)

Signature of Patient (or Legal Representative, if applicable)

If applicable, Legal Representative's Printed Name and Relation to Patient (e.g., Mother, Father, Guardian, etc.) or signature of witness (witness not required in Iowa, but may be in other states).