Phone: 319.730.7300
Fax: 319.730.7368

Medical Records Department
Eastern Iowa Health Center
PO Box 2205
Cedar Rapids, IA 52406-2205
EasternIowaHealthCenter.com

EASTERN IOWA HEALTH CENTER℠

CONSENT TO RELEASE OF INFORMATION

Patient Information
Name _____ **Date of birth** _____ **Phone #** _____
Maiden/previous names _____
Street address _____ **City** _____ **State** ____ **Zip** _____

I authorize Eastern Iowa Health Center to **release/receive** my health information specific to the information marked below:
(Circle one or both)

Information shall be sent to/from:
_____ _____
(charges may apply)
Street address _____
City _____ **State** _____ **Zip** _____
Phone _____ **Fax** _____
Email_____

Records Requested:
☐ **Consultation Notes** ☐ **Med Lists**
☐ **Operative Report** ☐ **Lab**
☐ **Admit/Discharge Summary** ☐ **Radiology**
☐ **History & Physical** ☐ **Immunizations**
☐ **Abstract (pertinent information)**
☐ **Other** _____
Specify dates if applicable: _____

Reason for Request
☐ Transferring Care ☐ Insurance coverage ☐ Info ONLY (release on file) ☐ Moving ☐ Legal purposes
☐ Personal Copy ☐ Care coordination—permission to release and receive verbal, written, or electronic medical information pertaining to health care

This authorization is effective for one year from the date on which it is signed. I understand that I may revoke this authorization in writing at any time by sending written notice to Eastern Iowa Health Center at the above address; except to the extent that action has already been taken in reliance upon it. I understand I have the right to inspect the information to be disclosed upon the proper notification. I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form. EIHC does not require completion of this form as a condition of evaluation or treatment. However, if the evaluation or treatment is solely for the purpose of creating a medical report for a third party, those services are subject to cancellation if authorization to release the information to that party is not provided. However, under Iowa Code Chapter 228 and the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2), persons and programs are not allowed to re-disclose alcohol and drug abuse treatment information without my written consent unless permitted to do so by law. Iowa Code Chapter 228 and other laws prohibit re-disclosure of mental health, alcohol and drug abuse treatment, HIV/AIDS and other confidential information without my written consent except in certain circumstances. I understand that not every organization that may receive a record is required to follow the rules governing use and disclosure of confidential information; in that circumstance, the information will no longer be protected by law and may be re-disclosed without my consent. I understand that I am entitled to a copy of this form upon request.
Electronic transmission of records (Faxing/E- mail) I authorize electronic transmission (fax/secure e-mail) of my medical records. If any portion of the fax/e-mail is received by an inappropriate third party in error, I release EIHC, its physicians and staff, of any and all liability relating to the disclosure of said records. Records may be provided in electronic form on a secure disk. I understand that information to be released may include material that is protected by Federal and/or State law concerning mental health, substance abuse treatment, AIDS–related information and genetics if I specifically authorize its disclosure below.

Specific Authorization for Release
I specifically authorize the disclosure of the following information:
Substance abuse (drug or alcohol) | Genetics
☐ Mental health information* AIDS–related information (diagnosis, & test results)

By signing this form, I authorize disclosure and re-disclosure of confidential information to the person or entity listed above. If mental health information is being disclosed, I acknowledge receipt of a copy of this authorization.

X_____ **Date**_____
(**Printed name of patient or legal representative***)
X_____
(**Signature of patient or legal representative***)

*Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.

EIHC Staff Initial: _____ ☐ **Faxed on _____**
**(Authority to act on behalf of patient requires attachment of such documentation)*