Medical Records Department
PO Box 2205
Cedar Rapids, IA 52406
Fax: 319-730-7368
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EASTERN IOWA HEALTH CENTER
Your health matters.

Consent to Release/Obtain Information

PATIENT INFORMATION

Name_____Date of birth _____
(MM/DD/YY)

Street address _____

City_____State_____Zip _____

Phone number_____Maiden/previous names _____

I authorize EIHC to: (CHECK CORRECT BOX) □ **Send Records to** □ **Receive Records from**

Name: _____
(Person/Organization Name)

Phone_____Fax_____

I would like records sent by: (CHECK PREFERRED METHOD) □ **FAX** □ **EMAIL** □ **OTHER** _____

_____
(EMAIL ADDRESS)

☐ **Keep on file (NO RECORDS SENT/RECEIVED)**
☐ **Abstract (office visits, x-ray, labs)**
☐ **Immunizations/Physical Form**
☐ **Other *(specific record)*** _____
☐ **Other *(specific dates of service)*** _____
☐ **Billing Summary**

PURPOSE OF RELEASE:

☐ Transferring medical care ☐ Case coordination/referral ☐Moving
☐ Legal purposes ☐ Request by patient **(personal copy)** ☐Other _____

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. For the information to be released, check the boxes below.

☐ Yes ☐ No Substance abuse (drug and/or alcohol)	☐ Yes ☐ No Genetics
☐ Yes ☐ No Mental health information	☐ Yes ☐ No HIV/AIDS Testing and Results

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, 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.	The Releasee 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.	My records are protected under the Federal Regulations governing Confidentiality of Substance Use Disorder Patient Records. Act, 42 CFR Part 2 and HIPAA 45CFR part 130 & 164. 42 CFR Part 2 prohibits unauthorized disclosure of these records. However, any disclosure of information carries with it the potential for redisclosure, and the information may not be protected by federal confidentiality laws.

Electronic transmission of records (Faxing/E-mail) I authorize electronic transmission (fax/secure e-mail) of my medical records. If any fax/e-mail is received by an inappropriate third party in error, I release EIHC, its physicians and staff of any/all liability relating to the disclosure of said records. Records may be provided in electronic form on a secure disk. Paper records are available upon request.
By signing this release form, I specifically authorize the disclosure and re-disclosure of this confidential information to the person or entity listed above.

Signature of patient or patient's legal representative_____**Date** _____
(MM/DD/YY)

Printed name and relationship of patient's legal representative_____
(Authority to act on behalf of patient requires attachment of such documentation)

☐ Faxed on_____☐ Records given to patient ROI Completed by: (staff initials) _____