CONSENT FOR RELEASE OF INFORMATION

Promise Community Health Center

33 4th St. NW, Sioux Center, IA 51250

Request Date: _____ Phone: (712) 722-1700 Fax: (712) 722-1770

Patient Name: _____ **Birth Date:** _____

I hereby authorize Promise Community Health Center to release any information, including diagnosis and records of any treatment or examination rendered to me. In addition, I also authorize return release of information to Promise Community Health Center from the referral individual, agency or other entity listed below.

_____

Name of Person or Institution

_____

Complete Mailing Address/Street/PO Box City State Zip Code

_____

Telephone Fax

Check all information to be disclosed – Information will be limited to the prior two (2) years, unless otherwise specified.

- ☐ Birth records, metabolic & hearing screen results
- ☐ Mammogram_____
- ☐ EKG (most recent)
- ☐ CT/MRI_____
- ☐ Progress notes/Office visits – Date range:_____(Two years if not specified)
- ☐ Lab results – Please specify type and approximate date: _____
- ☐ Dental records
- ☐ Other – Please specify type and approximate date: _____

In the following manner:

- ☐ Mail ☐ Fax ☐ Other_____
- ☐ Copies to be picked up by _____

As per my request, reason for release of information is:

- ☐ Copy for Self ☐ Referral ☐ Transition of care ☐ Insurance ☐ Legal
- ☐ Other (please specify) _____

Specific Authorization for Release of Information Protected by State or Federal Law

I authorize the release of the information listed below, which requires specific consent under Federal and State Law.

(Must initial any category that may be released)

Substance abuse_____ Mental Health_____ HIV related information_____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Promise Community Health Center. I understand that any release that was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Promise Community Health Center. A photocopy or fax of this authorization is as valid as the original.

I understand that Promise Community Health Center may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

This agreement will expire one (1) year from the date of signature, unless previously revoked or otherwise indicated.

_____ _____

Signature of patient or legal guardian Date

_____ _____

Relationship if not patient Nurse/Witness signature

This information has been disclosed to you from records protected by the Federal confidentiality rules (42 CRF 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 CRF 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 information to criminally investigate or prosecute any alcohol or drug use patient.

STAFF ONLY:

- ☐ Records Given
- ☐ Records Needed

Notes for Medical Records Specialist: