PROMISE COMMUNITY HEALTH CENTER
• mental health •

33 4th Street NW, Sioux Center, Iowa 51250 | 712-722-1700 | care@promisechc.org | promisechc.org

CONSENT FOR RELEASE OF INFORMATION

Request Date: _____ 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 of Institution Telephone

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

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