AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

NAME: _____ Email Address_____

DATE OF BIRTH: _____ CURRENT PHONE #:_____

MAILING ADDRESS: _____

I. GENERAL RELEASE **I authorize: Kossuth Regional Health Center** 1515 S. Phillips St or 1519 S. Phillips St **(provider/facility) to:**

☐ Release to OR ☐ Obtain from: _____

Facility Address, Physician Name, Fax #, Ph#_____

Dates/Types of information to be released is (list specifics – entire record, reports, i.e. labs, x-rays, etc.) **please list dates**

_____

_____

☐ **All past, present, and Future(1yr) encounters/visits for:_____**

II. SPECIAL RELEASE

I specifically authorize the release of:

1. Substance Abuse Records Initial ____
2. Mental Health Records Initial ____
3. HIV/AIDS Information Initial ____

Patient/RepresentativeSignature_____Date_____

Representative's Relationship to the Patient_____ KRHC Staff_____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR 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 abuse patient.
See also Chapter 228 and Chapter 141A of the Iowa Code and other applicable laws. **If mental health information is being disclosed, I acknowledge receipt of a copy of this Authorization.**

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 the Health Information Dept. I understand that any release, which 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 as a patient I have the right to access my records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand that Mercy Medical Center-North Iowa and Affiliated Clinics/Hospitals 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 authorization will expire on the following date, event, or condition_____. **If I fail to specify, this authorization will expire in twelve (12) months.** A photocopy of this signed authorization shall be as effective as the original.

_____ _____

Patient/Representative Signature **Date**

_____ _____

Representative's Relationship to the Patient **KRHC Staff Reviewed By**

HIM Internal Use Only:
Check if request has been completed (Faxed or Records Copied): ☐ Initial/Date_____
Patient Pick Up Only: ID Verified by_____ Date_____

Kossuth Regional Health Center
1515 S Phillips St
Algona, IA 50511
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