mahaskahealth

AUTHORIZATION FOR RELEASE OF INFORMATION

*A fee for reproduction may be assessed

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Patient Name:_____ Last four of SSN:_____ DOB:_____

Address:_____ Phone: _____

To / From (circle one)	To / From (circle one)
Mahaska Health Information Management	_____
1229C Avenue East Oskaloosa, Iowa 52577	_____
Ph: 641.672.3152 Fax: 641.672.3153	_____

Type of Information Required: ___ Surgery ___Lab ___ Discharge Summary ___Office Visit Notes ___Immunizations

___History & Physical ___Emergency Room ___X-Ray/Imaging Report Other:_____

Dates of Services: _____

Purpose of Release:

___Insurance ___ 2nd Opinion ___ Rehab/Disability ___ Moving Out of Area ___ Legal ___ Transferring Care ___ Other:_____

I understand that all information may be released electronically and may include information in the following categories unless I specifically deny the release.

(Please initial any category NOT to be released).

___Substance Abuse ___ Mental Health ___ HIV-Related Information ___Genetic Tests/Info

Section B: Patient must read and sign below

- This authorization is effective for 12 months. I understand that I may revoke this authorization at any time in writing except to the extent that action has already been taken in reliance upon it, by giving written notice to the Director of Health Information.
- I understand that authorizing the disclosure of this information is voluntary; I can refuse to sign this authorization. I need not sign this form to receive further treatment.
- I understand that I have the right to inspect the information to be disclosed upon proper notification and under appropriate conditions established by above named facility. The facility, its employees, officers, and attending physicians are released from legal responsibility or liability for release of above information to the extent indicated and authorized herein.
- I understand that I am authorizing the release of data and information relating to any/all substance abuse, mental health, HIV related information or assault and/or abuse information if not restricted in the specific description above.
- I have personally received and assume responsibility for any information I have received if transporting to another physician or institution listed above.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
- I understand the provider may deny request and I will be provided the reason for denial in letter format.

I hereby acknowledge that I have received a copy of this document.

Signature of Patient or Authorized Representative: _____ Date:_____

Authorized Representative Relationship to patient:____ Parent____ Power of Attorney:____ Guardian: ____ Other: _____

PROHIBITION OF REDISCLOSURES: This form does not authorize redisclosure of medical information beyond the limits of this authorization Where information has been disclosed from records protected by Federal Law for alcohol/drug abuse records (42 CFR Part 2), for mental health records (Iowa Code CH. 228), or HIV/AIDS records (Iowa Code CH. 141), federal requirements and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical information is not sufficient for these purposes. Once PHI is disclosed to others, it may be redisclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA. A photocopy, or exact reproduction of this authorization, as duly executed, shall have the same force and effect as the original.

OFFICE USE ONLY Completed By: _____Dept.: _____Date:_____ ☐ Verified with ID

Via: ___ Fax ___ Emailed ___ Mailed ___Given to Patient ___ Other:_____ ☐ Patient known to:_____

Employee Signature