Authorization for Access, Use or Disclosure of Protected Health Information

Patient Name (please print)_____ Medical Record # (for office use only)_____
Birth Date _____ Social Security #_____ Phone (home)_____ (work)_____
Address_____
City_____ State_____ Zip Code _____

I, the undersigned authorize and request Decatur County Hospital to:

☐ Allow access, use or disclosure of my protected health information to: OR ☐ obtain from:

Person/Organization_____
Address_____
City_____ State_____ Zip Code_____ Phone _____ Fax_____

Date(s) of Service: ☐**Copies as indicated below** ☐**Review only**

☐Discharge Summary ☐History & Physical ☐Emergency Room Note ☐Progress Notes ☐Operation Report
☐Consultation Report ☐Radiology Report/IMD/CD of films ☐EKG ☐Pathology Report ☐Laboratory Results
☐PT, OT, ST Eval/Notes ☐ Photographs ☐Other_____

Please explain why you are requesting access, use or disclosure to the above mentioned health record:

☐Continuing Medical Care ☐Insurance ☐Personal ☐Legal ☐ Law Enforcement
☐Other (please describe)_____

I specifically authorize the release of records that may include protected confidential information regarding:

☐Drugs or alcohol use/abuse, Initial:_____ ☐Mental Health, Initial;_____ ☐HIV/AIDS, Initial:_____

Decatur County Hospital may impose a fee of _____ to cover the cost of labor, copying, postage, and preparing a summary of the requested information. Do you agree to such fees imposed by Decatur County Hospital for providing a copy or summary of the requested information? ☐ Yes ☐ No

Prohibition on Conditioning of Authorization: Decatur County Hospital will not condition treatment on your signing this authorization unless: You are receiving research-related treatment; or The only reason the facility is providing you with healthcare is to make a report to a third party, such as your employer (e.g., P.E., Physical)

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, and State Law (Iowa Code ch. 228 & 141) for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, 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 or Other Information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Civil and Criminal Penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/AIDS information.

Expiration: This authorization is effective until (day, month, year)_____ or expiration of event (e.g., completion of a course of treatment or end of research study) but no longer than 1 year from the date on which it is signed.

Revocation: I understand that I may revoke this authorization at any time by notifying Decatur County Hospital in writing by sending a letter to Decatur County Hospital, Medical Records Department, 1405 NW Church Street, Leon, IA 50144 or completing the Revocation for Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Decatur County Hospital took before it received my revocation letter.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Decatur County Hospital's Notice of Privacy Practices.
Signature of Patient or Personal Representative_____ Date_____
Relationship to Patient_____

For Decatur County Hospital Use Only: Patient Identification Verified ☐Yes ☐No ☐Request Accepted ☐Denied
Witness/Received by_____ Date_____