***BELMOND MEDICAL CENTER***
***403 1st St SE***
***Belmond, Iowa 50421***
***Telephone: 641-444-5646***
***Fax: 641-444-4896***

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: _____ DOB: _____ MR# _____

Previous Name: _____ SS# _____ Phone # _____

**GENERAL RELEASE**

***Check One:***
_____ **HOSPITAL**
_____ **CLINIC**
_____ **HOSPITAL and CLINIC**

**I authorize (Facility/Provider Name):** _____

to release copies of my medical records to: _____, located at:

_____

**This request and authorization applies to (include dates where indicated):**

____ Discharge Summary ____ Consultation ____ History and Physical ____ Laboratory

____ Operative Report ____ EKG, EEG ____ X-ray ____ **ALL Health Information**

____ Other _____ (Specify)

**I Specifically Authorize The Release Of:**

____ **Mental Health Records** **Initials** ____
____ **Substance Abuse Records** **Initials** ____
____ **HIV/AIDS Information** **Initials** ____

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.

I understand this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Director of Health Information Management, Belmond Medical Center, 403 1st St SE, Belmond, IA 50421. 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 that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address. Copies of the records may be obtained with reasonable notice and payment of copying costs. I understand that BMC 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 year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____.**

_____ _____
**Signature of Patient or Legal Guardian** **Date**

_____ _____
**Complete Mailing Address** **Witness Signature**

**BMC Use Only**
**Completed & Documented in System By:** _____ **Date:** _____