GREAT RIVER HEALTH SYSTEM
AUTHORIZATION TO RELEASE INFORMATION

Patient's Name (first, middle initial, last)	Date of Birth	Release of □ Medical Records □ Billing Records

I do hereby authorize Great River Health System as indicated below
□ Southeast Iowa Regional Medical Center – West Burlington □ Home Health Care/Hospice
□ Southeast Iowa Regional Medical Center – Fort Madison □ Klein Center
□ Clinic(s)____

To disclose and/or deliver the following information related to the patient's treatment and/or services:
□ Discharge Summary □ History and Physical □ Operative Report □ Pathology Report
□ Emergency Department □ Clinic Notes/Progress Notes □ Medications □ Immunizations
□ Consultation □ Test [lab, imaging, etc.] results □ Other___________________________________

For dates of service from ________________________________ to ____

This information is to be released from Great River Health System to the Individual or facility specified below:

Name____

Address____Phone__________________Fax___________________

The information is being requested for the following reason(s)
□ Continuing/transferring care □ Insurance □ Legal □ Personal Use □Other_______________

I prefer the information be provided in the following method if possible
□ Hardcopy/Paper (unless otherwise specified) □ Electronic/CD □ Secure Portal □Other_______________

By signing this authorization form, I understand that:

- This consent may be revoked at by sending written notice to Director, Health Information Management, Great River Health System, 1221 S. Gear Ave., West Burlington, IA, 52655.
- Any release of information made prior to written revocation, in reliance upon this authorization, shall not constitute a breach of confidentiality;
- Disclosure of information carries with it the risk of unauthorized redisclosure and once disclosed it may no longer be protected by federal privacy regulations;
- Completing this form as a condition of treatment or payment is not required, however, when the service is solely for the purpose of completing a medical report for a third party or participating in research related treatment or disclosure of information for such purposes, refusal to sign this form may result in denial of these services.

Specific Authorization for Release of Information Protected by State or Federal Law
With this consent I specifically authorize the release of data and information relative to the following, **unless** I indicate the sensitive information that is **NOT** to be included wit this release (by checking and initialing box(es) below):
□ ___ Substance Abuse (alcohol/drug abuse) □ ____ Mental Health (includes psychological testing)
□ ___ HIV related information □ ____ Genetic Information

PROHIBITION ON REDISCLOSURE

If the information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2), 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient

This authorization will expire one year (12 months) from date signed or as specified here (number of days or months):_________ unless otherwise revoked (as directed above).

Signature:____ Date:______________________________
(Patient or Legal Representative only)

Address:____ Relationship:________________________________

City/State/Zip____ Witness:___________________________________

□ ID checked □ Sent by:_____________ □ Date Completed:_______________ □ ROI Tracking_____