Form 1989

CONSENT TO RELEASE OF INFORMATION

Hosp. #_____

University of Iowa Hospitals and Clinics (UIHC)
Health Information Management Department; Release of Information Office
200 Hawkins Dr., Iowa City, IA 52242 (Telephone 319-356-1719; FAX 319-356-3079)

Please use blue or black ink, neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name _____ **Birth Date** _____

List any previous names (maiden, married, legal changes) _____

By signing this form, I am allowing UIHC to release medical information concerning the above named patient to the person or facility listed below. Information may be shared by: Viewing ___ Verbal ___ Copies X CD ___ CareLink ___ MyChart___
(Please note, burning to a CD is only possible when transferring electronic information. Copies of paper documents will be provided on paper.)

Black Hawk Area Special Ed. District, Attn: Don Kearney — (309) 796-2911
Name of Person and/or Institution who will receive information — FAX # (If urgent)

4670 11th Street — East Moline, IL. 61244
Complete Mailing Address/Street/P.O. Box — City, State, Zip Code

Check the information to be disclosed (include dates if known): _____Minimum necessary, or specify as follows:

X Medication list _____ Allergy list _____ Immunization record
X History and Physical, specify clinic or date _____
___ Discharge summary, specify clinic or date _____
___ Laboratory results, specify type or date _____
___ Radiology reports, specify type or date _____
___ Radiology images on CD, specify type or date _____
___ Consultation reports, specify doctor or clinic _____
___ Test results (e.g. EKG, PFT, etc.), specify type or date _____
___ Billing Information, specify _____
X Other, specify Diagnosis, Medications & Restrictions.

Please check the reason for release below; and provide a date by which the info is needed: ASAP

Moving out of area _____ Rehab/disability DHS-DRS Insurance _____ 2nd opinion _____

Personal file _____ Legal _____ Other medical care _____ Transferring care _____

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) 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.

UIHC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.

I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (***initial*** **any category *not* to be released).**

Substance Abuse_____ Mental Health _____ HIV-related information _____ *Genetic tests/info_____

*Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement allows release of past and future information and will expire two years from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

_____ _____ _____
Signature of Patient or Legal Guardian — Printed name — Date

_____ _____
Complete Mailing Address/Street/P.O. Box — City, State, Zip Code

_____ _____
Relationship, If Not the Patient — Witness Signature

UIHC use only: *Upon satisfying this release, date & sign; record on the Release of Information Tracking (ROIT) system and scan the form in to Epic. If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, complete the following as appropriate and then forward to the Release of Information Office, Health Information Management (HIM) Department, at address above.*

Information sent by: _____ _____ _____
Name — Department — Date