

MEDICAL RECORDS RELEASE OF INFORMATION DEPARTMENT:

5880 UNIVERSITY AVE, STE 209 • WEST DES MOINES, IA 50266 • PHONE: 515-633-3880 • FAX: 515-246-4485

AUTHORIZATION TO RELEASE INFORMATION

COMPLETE ALL FIELDS AND PRINT CLEARLY, FAILURE TO DO SO MAY PREVENT OR DELAY RELEASE OF INFORMATION.

Address Street Date of Birth Soc Sec # Acct # I authorize information from my medical record to be released (please include address & fax if available): SEND TO; Person/Place; Person/Place; Address; Address; Address; Address; Phone/Fax: Phone/Fax: **** SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW** PLEASE CHECK EACH BOX YOU DO NOT AUTHORIZE I specifically do not authorize the release of information which may include or relate to: STD / HIV-related information Genetic Information PLEASE INDICATE RECORDS TO BE RELEASED - Pertininent records - Most recent office visits, hospital visits, Operative reports, and testing Medical records from dates of service to Chefr (Please specify) Other (Please specify) Chefr (Please specify) Chefr (Please describe): Please be aware that MercyOne lowa Heart may impose a fee to cover costs involved in processing this release of informate Prohibition on Conditioning of Authorization: MercyOne lowa Heart Center will not condition treatment on your signing this authorization unite • You are receiving research-related treatment; or health information may potentially re-disclose it. However, Federal Law (42 CFR Part 2) for hospital coloribid in the information used and/or disclosed according to this authorization may no longer be protected by federal private law (slock) or school (e.g., athletic participation). Redisclosure: Unineerstand that the information used and/or disclosed according to this authorization may no longer be protected by federal private law (slock) or school (e.g., athletic participation). Redisclosure: Unineerstand that the information used and/or disclosed according to this authorization may no longer be protected by federal private law (slock) or school (e.g., athletic participation). Redisclosure: Unineerstand that the information used and/or disclosed according to this authorization and inclosed from record or the information to crimin	Patient Name		First		Middle Initial
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□ Testing (Please specify) □ Other (Please specify) □ Reason for Request: □ Continued Care □ Transferring Care □ Insurance □ Personal □ Moving □ Lega □ Other (please describe): Please be aware that MercyOne lowa Heart may impose a fee to cover costs involved in processing this release of informat Prohibition on Conditioning of Authorization: MercyOne lowa Heart Center will not condition treatment on your signing this authorization unle You are receiving research-related treatment; or • The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., athletic participation). Redisclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privace law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, and State law (lowa Code ch. 228 & 141) for Mental Health and HIIV/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 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 (eg end of research study) but no lond 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 MercyOne lowa Heart Center in writing by sending a letter to MercyOne lowa Heart Center Medica		•	•	•	
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FOR OFFICE USE ONLY: Completed By: _____ Location: ____ Date: ____ Fee Due: ____ Fee Paid: ____