Community Memorial Hospital
UnityPoint Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Community Memorial Hospital and CMH Medical Clinic
909 West First Street
PO Box 148
Sumner, IA 50674
Phone: (563) 578-3275 Fax: (563) 578-2146

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. This authorization if effective for ____ months but no longer than 1 year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Community Memorial Hospital. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Community Memorial Hospital. In support of your privacy, Community Memorial Hospital does not accept your blanket authorization to disclose health information of treatment not yet received. A new authorization will be required for each new episode of care. I understand my health care and payment for my health care will not be affected by this authorization.

INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.

PATIENT IDENTIFICATION:
Name: _____ Date of Birth: _____
Address: _____
_____
Phone Number(s):_____

PROVIDER: (Who is releasing the information)
Name: _____
Address: _____
_____
_____

REQUESTOR: (Where do you want the information sent)
Name: _____
Address: _____
Fax: _____

INFORMATION REQUESTED:
_____ Discharge Summary, Date: _____ _____Consultation Report, Date: _____
_____ Lab Report, Date: _____ _____ X-Ray Report, Date: _____
_____ Operative Report, Date: _____ _____ ED Report, Date: _____
_____ EKG, Date: _____ _____ H & P Report, Date: _____
_____ Progress Note, Date: _____ _____ Billing Information (Specify): _____
_____ Only Records Pertaining To: _____

PURPOSE OF RELEASE:
_____ At Request of Patient or Legal Representative
_____ Transferring Medical Care _____ Other: _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ DATE: _____
RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to:

Initials required by category:

_____ 1. Substance abuse treatment. (Alcohol/drug)
_____ 2. Mental health (includes psychological testing)
_____ 3. HIV-related information (AIDS related testing)

PROHIBITION OF REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch. 228) prohibit further disclosure without 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. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ DATE: _____
RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT: _____