AUDUBON COUNTY MEMORIAL HOSPITAL
515 PACIFIC AVE, AUDUBON, IOWA 50025 712-563-2611

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name _____ **Date of Birth** _____**MR#** _____

I authorize Audubon County Memorial Hospital to release my health information to:
(Recipient) _____
Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Legal-Guardian ☐Provider ☐other_____

For the Purpose of: ☐Continuing Medical Care ☐Personal Records ☐Other_____

Deliver Record by: ☐Mail to: _____
☐Fax to: _____ ☐Pick up on: _____

Date(s) Service/Episode Requested_____
Health Information Requested:
☐Discharge Instruction ☐Emergency Record ☐Consultation Report ☐Inpatient/Acute Record ☐Swing Bed Record
☐Operative Report ☐Pathology Report ☐Laboratory Report ☐Radiology Report ☐Radiology Images
☐Other_____ ☐Patient Portal ☐Entire Record From _____to_____

I understand any Federal/State laws protected health information of more sensitive information listed in this box is included. I authorize the following to be released: ☐AIDS/HIV ☐Mental Health ☐Drug/Alcohol
☐GINA (Genetic Testing) Screening Data/Family Genetic History

Signature _____ Date _____

- I understand that I may inspect this information and I may request copies for a fee.
- I understand that I may revoke this authorization at any time by notifying Health Information Management Department in writing; however, the revocation will not apply to the information already released in accordance with the authorization.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, except as permitted by law.
- I understand that the information disclosed may be re-disclosed by the recipient and no longer protected by the federal patient privacy and security regulations. The recipient may, however, be prohibited from disclosing substance abuse, and/or mental health information under federal regulations.
- I understand this authorization will expire 60 days from the date listed below.
- I understand I will be provided a copy of this authorization. (Copy provided by _____)

_____ _____ _____
Signature of Patient or Legal Representative **Relationship** **Date**

_____
Witness Signature

VERBAL REQUEST: Request was taken via phone instead of in person. Complete the boxes above and in this section.
Parent/Patient on Phone _____
Witnesses (2) _____ Date _____

Staff Section: Did you confirm patient has on file a POA or Appointment of Representative? ☐Yes ☐No ☐ Not Applicable
Who Completed Form _____ Who Released Record _____Date _____