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 _____ **MEDICAL RECORD #** _____

As required by the Health Information Portability and Accountability Act of 1996, you have a right to designate one or more persons to act on your behalf with respect to your protection of health information.

By completing this form you are informing us of your wish to designate the named person(s) as your personal representative. This is not a patient authorization and does not authorize Audubon County Memorial Hospital to use or disclose protected heath information to any organizations or people except those listed below.

You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to our Health Information Management Department.

I give my consent for those listed to be afforded all of the privileges as I would have with respect to my protected health information in the following areas: **Mark the boxes below that you want the representatives to have access.**

☐Laboratory results, radiology reports and office notes including diagnosis, treatment and status.

☐Billing information

☐**ALL** medical information

☐Access to electronic Patient Portal

☐**DOES** ☐**DOES NOT** include information pertaining to AIDS/HIV, Mental Health, Drug/Alcohol, Genetic Screening Data/Family Genetic history

Consent is given to the family members or personal representatives listed below:

NAME	RELATIONSHIP	DATE
__Add names here to have access to your records_	___Friends, neighbors, family_____	_____
__This includes nurses/doctors speaking_____	_____	_____
___more indepth about your care_____	_____	_____
_____	_____	_____

_____ _____
Patient's Signature **Date**

REVOCATION SECTION - Only if you want to void this authorization.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Audubon County Memorial Hospital at 515 Pacific Ave, Audubon, IA 50025. I further understand that any such revocation does not apply if that person or persons authorized to us or disclose my protected health information have already taken action on my behalf.

I hereby revoke my consent for this appointment of representative form.

_____ _____
Patient's Signature **Date**