EROI

UnityPoint Health

# UnityPoint Health Authorization/Request for Release of Medical Information

**INSTRUCTIONS:**

**PATIENT IDENTIFICATION**

**Make sure all blanks are filled in. Failure to do so could prevent or delay processing**

Name (Legal/Maiden/Other) _____

Address _____

City_____ State_____ Zip_____ Phone #_____

Date of Birth_____ Social Security Number (optional)_____

**PROVIDER/ ORGANIZATION** (Who is authorized to release the information)

Provider Name_ _____

Address_____

City_____State_____Zip_____

**REQUESTOR:** (Where do you want the information sent)

Requestor Name UnityPoint Health - Des Moines Iowa Methodist Transplant Center Phone # (515) 241-4044

Address 1215 Pleasant Street, Suite 506 Fax # (515) 241-4220

City Des Moines State IA Zip 50309

**INFORMATION REQUESTED:** *charge may apply*

Service Dates _____

☐Abstract (all physician dictations/test results) ☐ Lab/Radiology Results ☐Entire Record

☐Other, please specify _____

**PURPOSE OF RELEASE:**

**(Check all that apply)**

☐Continuing Care ☐Insurance Coverage ☐Legal ☐SSA/Disability ☐Personal Use

☐Other_____

**Requested Format**:

☐Paper ☐CD (Password Protected):

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

I authorize the release of the information listed below, which requires specific consent under federal law: **(check all that apply)**
**(Note: Depending on what is checked we may be unable to fulfill this authorization.)**

❑Substance Abuse ❑ Mental Health Treatment (excluding psychotherapy notes) ❑ HIV/AIDS related testing

Signature of Patient or Authorized Representative: X_____ Relationship_____

Witness Signature (Illinois Only): X _____

X_____

***ILLINOIS ONLY*:** Minor's signature required if ages 12-17 for mental health records.

**For Illinois or Wisconsin Residents Only:** Under state law, you must separately and expressly authorize release of any of the following confidential information (check those that apply for your state): ❑ Genetic Testing (**Illinois**) ❑ Sexual Assault (**Illinois**)

❑ Child Abuse/Neglect (**Illinois**) ❑Abuse of Adult with a Disability (**Illinois**) ❑ Developmental Disabilities (**Wisconsin and Illinois**)

Signature of Patient or Authorized Representative: X_____ Relationship_____

**This authorization is 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 the Medical Records Department of the source facility. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the source facility. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. I understand that I am entitled to receive a copy of this completed authorization form.**

Prohibition of re-disclosure: This form does not authorize re-disclosure 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, and HIV/AIDS tests results, federal requirements (42 CFR Part2) and state requirements (IA Code ch.228&ch.141) (740 Ill. Comp. Stat. § 110/5) (Wis. Code §§252.15(6), 50.30) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS related testing and or treatment.

_____
Signature of Patient or Authorized Representative

_____
Print Name/Relationship to Patient

_____
Date