HIM ROI Authorization

UnityPoint Health

Authorization/Request for Release of Health Information

Please complete all sections, date, and sign. Missing or incomplete information may delay processing.

1. PATIENT INFORMATION

Name (Legal/Maiden/Other) _____ Date of Birth_____

Phone Number_____Address_____

City_____ State_____ Zip_____

2. RELEASE INFORMATION FROM (SENDER)

I AUTHORIZE UNITYPOINT HEALTH (UPH) AND ITS CLINICAL AFFILIATES TO RELEASE INFORMATION FROM (CHECK ALL THAT APPLY):

Hospitals (*including hospital-based clinics)*: ☐ All Hospitals listed below

☐ Finley Hospital	☐ Allen Hospital	☐ Iowa Methodist Medical Center
☐ Jones Regional Medical Center	☐ Meriter Hospital	☐ John Stoddard Cancer Center
☐ St. Luke's Hospital Cedar Rapids	☐ Grinnell Regional Medical Center	☐ Methodist West Hospital
☐ Trinity Bettendorf	☐ Marshalltown Hospital	☐ Trinity Regional Medical Center
☐ Trinity Rock Island	☐ Iowa Lutheran Hospital	☐ St. Luke's Sioux City-Downtown
☐ Trinity Moline	☐ Blank Children's Hospital	☐ St. Luke's Sioux City- Main
☐ Trinity Muscatine		☐ June E Nylen Cancer Center

Clinics: ☐ All Clinics listed below

☐ UnityPoint Clinic (All)
☐ Meriter Clinics (All)
☐ Blank Children's Clinics (All)
☐ PACE (Program of All-Inclusive Care for the Elderly)
☐ UnityPoint at Work/Occupational Health (All)
☐ Specific Clinic/Provider (please specify):_____
_____

Behavioral Health/ Substance Use Disorder Programs(s): (Check All That Apply)

☐ Abbe Center for Community Mental Health	☐ Black Hawk Grundy Mental Health	☐ Robert Young Center
☐ Abbe Associates for Behavioral Health	☐ Center for Alcohol & Drug Services, Inc (CADS)	☐ St. Luke's Cedar Rapids Chemical Dependency
☐ Abbe Aging Services	☐ Eyerly Ball	☐ Other Specific Program (please specify): _____
☐ Allen Recovery Center	☐ Meriter NewStart	_____
☐ Berryhill Center	☐ Powell Chemical Dependency	
	☐ Riverside Drug & Alcohol Services	

UnityPoint at Home ☐ All Services listed below

☐ Home Care
☐ Hospice
☐ Home Medical Equipment (HME)
☐ Specialty Pharmacy
☐ Infusion Therapy

☐ **Other Location Not Listed** (please specify; name, address, fax and phone if available): _____
_____

3. SEND MY INFORMATION TO (RECIPIENT)

Name: _____ Phone Number: _____

Address: _____City: _____

State: _____ Zip: _____ Fax Number: _____

Email Address: _____

☐ **CHECK THIS BOX TO ALLOW RECIPIENT TO SHARE INFORMATION BACK TO THE UPH RELEASING PARTY**

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4. INFORMATION TO BE RELEASED FROM YOUR HEALTH RECORD

Dates of Service: From: _____ **To**: _____

**For Care/Treatment purpose only- If no dates are listed, the last 24 months will be provided*

Information may include ☐ Mental Health ☐ Genetic Testing ☐ Substance Use ☐ HIV/AIDS Testing

**Depending on what is checked we may be unable to fulfill the request.*

SELECT INFORMATION TO BE RELEASED FROM YOUR HEALTH RECORD

Document/Note(s) (check all that apply)

☐ Provider Notes
☐ Operative/Procedure Reports
☐ Behavioral /Psychological Note
☐ Therapy Notes (physical, occupational, speech)
☐ Plan of Care/Treatment Plan
☐ Home Care OASIS
☐ Other, specify_____

Other Records (check all that apply)

☐ Diagnostic Test Results (lab, radiology, cardiology, sleep study, etc.)
☐ Medication List
☐ Immunizations
☐ Sexual Assault/ Child Abuse/Neglect /Abuse of Dependent Adult
☐ Itemized Billing Statement
☐ Image(s) Cardiac/Radiology, specify exam(s)/body parts: _____
☐ Other, specify: _____

Substance Use Disorder (SUD) and Addiction Treatment Records (Check all that Apply)

☐ Assessment/Evaluation (ASAM)
☐ Discharge Plan
☐ SUD Treatment Plan
☐ Attendance
☐ Psych/Social History
☐ Drug Test/Screening Results
☐ Other, specify_____

5. RELEASE PURPOSE (CHECK ALL THAT APPLY)

☐ Disability ☐ Insurance ☐ Legal ☐ Care/Treatment ☐ Financial Assistance ☐ Personal
☐ Other (Specify): _____

6. DELIVERY FORMAT

Preferred method (select one): ☐ Printed Copy ☐ Verbal Only (*care coordination)*

Printed Copy will be mailed on paper to the address in section 3 unless an alternate method is checked. *(fee may apply)*

☐ MyUnityPoint Patient Portal ☐ Fax (number listed in section 3) ☐ CD/DVD ☐ Email (address listed in section 3)
☐ Other instructions: _____

7. EXPIRATION

This authorization remains valid until calendar date of ___/___/_____, or if left blank one year from the date it is signed and permits the release of records after the signature date for the time period specified in section 4.

8. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

By signing below I understand:

- I may revoke this authorization by providing written notice of revocation to the Release of Information (ROI) department at the releasing facility, except to the extent that action has been taken in reliance on this authorization.
- I do not have to sign this authorization. My health care will not be affected if I do not sign this form.
- Information may be redisclosed by the recipient and may no longer be protected by state or federal law.
- I have the right to inspect or obtain copies of the information released. I may receive a signed copy of this authorization if requested
- **TO THE RECIPIENT OF INFORMATION:** Substance use disorder records are protected by regulations found at 42 CFR Part 2; the Health Insurance Portability and Accountability Act (HIPAA), and the Privacy Act of 1974. Unauthorized use or redisclosure of these records is prohibited without patient consent or as otherwise provided by law. In addition, HIPAA and state laws may prohibit use or redisclosure of other sensitive information. The records cannot be released without patient consent or unless otherwise provided by these laws. Unauthorized use or disclosure is unlawful and may result in civil damages and criminal penalties.

9. SIGNATURE(S)

Signature of Patient/Authorized Representative: _____

Printed Name: _____ Relationship (if not patient): _____

Minor's signature _____ Date: _____

(Illinois Only, required if ages 12-17 for mental health records)

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Instructions

Section 1: Enter the patient's legal name, address, phone number, and date of birth.

Section 2: Check the box(es) for the UnityPoint Health (UPH) organization(s) that will share or release the patient's information ("Releasing Party"). For Hospitals, this includes hospital-based clinics, which are considered outpatient departments of the hospital. Use "Other Specified" for, a specific individual clinic, a location not listed, or for use with a non-UnityPoint location. Please note that you may receive multiple responses to your record request depending on the location(s) you request records from and what records are requested. To request records from a Community Network Hospital, use "Other Specified Location" or contact the facility directly.

Section 3: Enter the name of the individual or organization to receive the patient's information ("Recipient"). For example, the name of another provider, attorney, an insurance company, or a family member or friend. If you want to authorize the ("Recipient") to share health information back to the Releasing Party, check the box in the header of section 3.

Section 4: Check the box(s) for the information to be released. If you want your entire medical record, check "Other, specify" in the Additional Records area and write entire record on the line.

Section 5: Indicate the reason you are requesting the release of your health information. The purpose you provide may determine any fees associated with releasing your records. **Important:** If you are filling out this authorization so that UnityPoint at Home can share your health information with drug manufacturers for the purpose of being considered for a manufacturer's financial assistance program, please select "UnityPoint at Home" in Section 2, enter "Manufacturers of drugs that I have been prescribed" in Section 3, and select "Financial Assistance: in Section 5 .

Section 6: Indicate the format in which the requested information should be provided. If you request information by email or CD, UnityPoint Health will send your information using encryption or password protection. If you wish to receive your information via unencrypted email or a CD without password protection, please specify this preference in the Other Instructions section. Kindly be aware that such methods may expose your information to potential access by unauthorized individuals.

Section: 7 Enter the specific calendar date you want the authorization to expire or leave blank to default to 1 year from date signed.

Section 8: Read the statements about your rights carefully.

Section 9: Sign and date the form. If you are a personal representative, which means a person who has legal authority to act on behalf of an individual in making health care-related decisions, such as a legal guardian or someone with authorized Power of Medical Attorney—please also provide your contact information and state your relationship to the patient. Be sure to submit a copy of legal guardianship papers, valid Power of Attorney for Health Care, or Executor of Estate documentation along with this authorization if you have not already done so.

Return completed form to the specific facility being requested. Requests asking for all records of UnityPoint Health may be returned to UPH_HIM_ROIRequest@unitypoint.org. Visit https://www.unitypoint.org/patients-and-visitors/medical-records for additional contact information.