IOWAHEARTCENTER

Iowa Heart
MEDICAL RECORDS
RELEASE OF INFORMATION DEPARTMENT:
5880 UNIVERSITY AVE, STE 209 • WEST DES MOINES, IA 50266
PHONE: 515-633-3880 • FAX: 515-246-4485

Authorization/Request for Release of Medical Information

Instructions **PATIENT INFORMATION**	**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: _____
RELEASING ENTITY (Who is authorized to release the information)	Provider Name:_____ Address:_____ City:_____ State:_____ Zip _____ Phone:_____ Fax_____
RECEIVING ENTITY: (Where do you want the information sent)	Requestor Name:_____ Address:_____ City:_____ State: _____ Zip:_____ Phone:_____ Fax:_____
INFORMATION REQUESTED (Charge may apply)	Service Dates:_____ ❑ Abstract (all physician dictations/test results) ❑ Entire Record ❑Laboratory reports ❑ Immunization records ❑ EKG/Cardiology Testing ❑ Radiology images/reports ❑ Discharge summary ❑ History & Physical ❑ Clinic notes ❑ Other (specify information to be released)_____
PURPOSE OF RELEASE (Check all that apply)	❑ Continued Care ❑ Insurance ❑ Legal ❑ Moving ❑ Personal ❑ Transferring Care ❑ Other_____
REQUESTED FORMAT	❑ Paper ❑ CD (Password Protected) ❑ Mailed ❑ Faxed to:_____ ❑ Call _____ at (phone #)_____ Pick up Date_____ Please allow 30 days after date of request if wishing to pick up in person

8310-354-W-2s (New 5-14-18)

Patient Chart Copy

***** SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW*****
PLEASE CHECK EITHER YES OR NO IN EACH APPLICABLE LINE TO RELEASE THE SPECIFIC INFORMATION:

Substance Use/Abuse ❑ YES ❑ NO Mental Health ❑ YES ❑ NO

STD /HIV-related information ❑ YES ❑ NO Genetic Information ❑ YES ❑ NO

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient, if not signed by Patient

Prohibition on Conditioning of Authorization: Mercy Medical Center, Mercy Clinics or Iowa Heart Center will not condition treatment, payment or enrollment/eligibility for benefits on signing this authorization unless:

- You are receiving research-related treatment or
- The only reason the facility is providing you with health care is to make a report to a third party such as your employer(e.g., fitness to return to work) or school (e.g., athletic participation.

EXPIRATION: This authorization is effective for _____ months but no longer than one year from the date on which it was signed.

REVOCATION: I understand I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving a written notice.

INSPECTION: I understand I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Mercy Medical Center, Mercy Clinics and Iowa Heart Center.

PLEASE BE AWARE THERE MAY BE A FEE ASSOCIATED WITH YOUR REQUEST

The statement made in this authorization are binding, controlling and I understand that they take precedence over statements in the organization Notice of Privacy Practices.

Signature of Patient or
Legal Representative: _____ Date: _____

Relationship to Patient,
If not signed by Patient: _____ Witness: _____

PROHIBITION OF REDISCLOSURE
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2) and state requirements (Iowa Code, ch 228). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

OFFICE USE ONLY:
Medical Record #:_____ Account #: _____

Date Information Sent: _____ Person Releasing Records: _____

Fee Due: _____ Fee Paid: _____