ST. ANTHONY Regional Hospital

311 South Clark Street
PO Box 628
Carroll, IA 51401
(712) 792-3581

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____ Record No._____
(please print)

I, the undersigned, do authorize and request _____
(Provider to release information)

to release information to _____
(Name of person / provider to receive information)

_____ _____
Complete Mailing Address / PO Box City / State / Zip Code

Check the information to be disclosed (include dates where indicated) Minimum necessary or specify:

- □ Summary of Stay Including Discharge Summary, Discharge Instruction, History and Physical Examination, Consultation and Operative Report for the Following Date(s): _____
- □ Clinic Notes for the Following Date(s): _____
- □ Other, please specify: _____

Purpose of releasing the information: _____

I understand that the records released may contain information related to the following and I authorize its release: **(Please initial by all those that apply)**

_____ Mental Health* _____ Drug and Alcohol Abuse* _____AIDS/HIV related information*

* I understand that the confidentiality of these records will be protected in compliance with state and/or federal law. No information will be released without my written consent unless disclosure is permitted by court order, or to medical personnel in a medical emergency or for research/monitoring programs.

(Over for Signature)

Health Information Management Phone: (712) 794-5557 Fax: (712) 794-5480

Patient Name: (Please Print) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to: Director of Health Information, St. Anthony Regional Hospital, PO Box 628, Carroll, IA 51401. The cancellation will not be effective until received by the above.

I understand that any release that was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure and once information is disclosed it may no longer be protected by federal privacy regulations.

I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address.

I understand that St. Anthony may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months or date) _____

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Complete Mailing Address / PO Box City / State / Zip Code

_____ _____

Relationship if not the patient Witness Signature

_____

Expiration Date of Authorization

By completing this form you will only receive hospital (not clinic) records.

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