Name of Patient _____ Medical Record # _____

Date of Birth _____ Date(s) of treatment: _____

I hereby authorize _____ of MercyOne Medical Center, ❒ Dubuque, IA ❒ Dyersville, IA

❒ disclose to: _____ ❒ obtain from: _____

Address: _____

the following information contained in the medical records of the above named patient. This information may be verbal, written, or copies of such records.

MEDICAL RECORD

❒ Face sheet (ID/diagnosis/procedures)	❒ Operative Report	❒ Discharge Summary (counselor)
❒ Discharge Summary/History	❒ Complete Record	❒ Continuing Care Plan
❒ History/Physical Examination	❒ Pathology Report	❒ PT, OT, SP, PC Notes
❒ Mental Health History	❒ Nurses Notes	❒ Verbal Progress Report
❒ Psychosocial/Social History	❒ Dr. Order/Progress	❒ Substance Abuse Assessment
❒ Mental Health Progress	❒ EEG/EKG/Stress Test	❒ Integrated Summary
❒ Psychologist Evaluation/Report	❒ Heart Cath Report	❒ Family Assessment
❒ Mental Health Evaluation	❒ Medications	❒ Recommendations
❒ X-Ray Reports	❒ Emergency Room Report	❒ Progress Staffing
❒ Lab Reports	❒ Treatment Participation/Plan	❒ Other _____
❒ Consultation Other Physicians	❒ Treatment Plan & Updates	❒ Other _____

This authorization is provided for the following purpose: _____

❒ This information has been disclosed to you from records protected by Federal and Iowa State Confidentiality rules, 42 CFR, Part 2, Iowa Chapter 228, and/or Section 141.23 (3) of the Iowa Code. These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

I specifically authorize the release of ❒ Mental Health Initial _____

❒ All Substance Abuse Initial _____

❒ HIV (Aids) information Initial _____

I understand that my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or request a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Medical Record Department.

_____ _____ _____

Date **Time** **Patient Signature/Patient Representative**

_____ _____

Witness **Relationship**

MercyOne Medical Center Authorization to Release and/or Receipt of Confidential Information

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