AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

The Gabrielson Clinic
1316 South Main Street Clarion, Iowa 50525
Phone: (515) 532-9287
Fax: (515) 532-3844

Patient's Name: _____ DOB: _____ Phone# _____
Previous Name: _____

GENERAL RELEASE **I authorize The Gabrielson Clinic for Women to:**
☐ **Release my medical records to:** _____ ☒ **Obtain my medical records from:** _____

_____
Clinic/Provider Address **City, State** **Phone** **Fax**

This request and authorization applies to (*include date of service requested*): Date of Service _____

☐ Discharge Summary ☐ Consultation ☐ History & Physical ☐ Laboratory ☐ Operative Report
☐ EKG, EEG ☐ X-ray ☐ Clinic Note ☒ All health care information
☐ Mammogram images and reports Permanent Transfer? ☐ Yes ☐ No
Other (Be Specific) _____

I Specifically Authorize the Release of:
☒ Yes ☐ No Mental Health Records Initials _____
☒ Yes ☐ No Substance Abuse Records Initials _____
☒ Yes ☐ No HIV/AIDS Information Initials _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal 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 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient. See also Chapter 228 and Chapter 141A of the Iowa Code and other applicable laws.

I understand this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Director of Health Information Management, Iowa Specialty Hospital Campus - Belmond, 403 1st St SE, Belmond, IA 50421 or Iowa Specialty Hospital Campus – Clarion, 1316 South Main St, Clarion, IA 50525. I understand that any release, which 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 redisclosure 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. Copies of the records may be obtained with reasonable notice and payment of copying costs. I understand that Iowa Specialty Hospital 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. *Revised 12/18/2014*

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

_____ _____
Signature of Patient or Legal Guardian **Date** **Witness Signature**

_____ _____
Street Mailing Address or PO Box (REQUIRED) **City, State Zip (REQUIRED)**

****IDENTITY VERIFICATION – REQUIRED TO RELEASE INFORMATION****

Released by: _____ **Date:** _____

Verification Type: _____ **(Photo ID / DOB / SSN / Identity known by releaser)**