PHC
primary health care

Authorization for Release of Protected Health Information

Patient Information

Name _____ Date of Birth _____ Last 4 digits of SSN (optional) _____

Street Address _____ City _____ State _____ Zip _____

Phone _____

Purpose of Release

❑ Transfer of Medical Care ❑ Insurance Coverage ❑ Care Coordination/Referral ❑ Other _____

❑ Moving ❑ Legal Purposes ❑ Request by Patient

Release of information from

❑ Primary Health Care Inc.
Centralized Medical Records Dept.
1200 University Ave., Suite 200
Des Moines, IA 50314
Fax: (515) 248-1832

❑ Other *(please specify)*
Name _____
Address _____
Phone _____ Fax _____
Email _____

Release of information to

❑ Patient

❑ Primary Health Care Inc.
Centralized Medical Records Dept.
1200 University Ave., Suite 200
Des Moines, IA 50314
Fax: (515) 248-1832

❑ Other *(please specify)*
Name _____
Address _____
Phone _____ Fax _____
Email _____

Information to be released

❑ Requesting Records *(Last 1 year within chart)*
Office Visits
Lab/Radiology Results
Problem/Medication List

❑ Requesting Records *(Last available within chart)*
Cancer Screens *(mammograms, PSA, PAP, CRCS, etc.)*
DEXA
Specialist Reports, Biopsy Reports

❑ Diagnostic Testing *(endoscopy, cardiac echos, stress tests)*
❑ Billing Records *(please specify)* _____
❑ Immunization Records

❑ Other _____

Electronic transmission of records (faxing/email) I authorize electronic transmission (fax/secure email) of my medical records. Records may be provided in electronic form on a secure disk. Paper records are available upon request.

Specific Authorization for Release of Information Protected by State or Federal Law

I authorize the release of the information listed below, which requires specific consent under federal law: (check all that apply)
(Note: Depending on what is checked we may be unable to fulfill this authorization.)

❑ Substance Abuse *(drugs or alcohol)*

❑ HIV/AIDS Related Information

❑ Mental Health Treatment, Diagnosis, Test Results *(excluding psychotherapy note)*

❑ Genetics

_____
Signature of Patient or Authorized Representative

_____
Print Name/Relationship to Patient

This authorization is effective for ____ months but no longer than 1 year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Primary Health Care, Inc. I understand that I have the right to inspect the information to be disclosed upon proper notification to and under conditions established by Primary Health Care, Inc. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. I understand that I am entitled to receive a copy of this completed authorization form.

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.

_____
Signature of Patient or Authorized Representative

_____
Print Name/Relationship to Patient

_____
Date

_____
Witness Signature

PHC use only: Upon satisfying this release, scan the form into GE Centricity, index under Consent ROI EMR, with summary type ROI Processed, ROI Not Processed or Records Requested based on status and attach to Medical Records Document.

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