Des Moines University Clinic, H.I.M. Dept.
3200 Grand Avenue, Des Moines, IA 50312
Phone (515) 271-1700 Fax (515) 271-1726

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I give permission to use and/or disclose my health information as described below. This authorization is effective one year from the date on which it was signed. I understand I may revoke this authorization at any time except to the extent that action has already been taken by giving written notice to Des Moines University (DMU) at the address listed above. I understand I have the right to inspect or receive a copy the information disclosed by notifying DMU at the address listed above and following the process established by DMU. I understand treatment and payment for my healthcare will not be affected by this authorization.

Please print the following information and check all boxes that apply:

Patient Identification	Name _____ Date of Birth _____ Phone _____
Who is to disclose the information	☐ Des Moines University **OR** ☐ Name _____ Address _____ City, State, Zip _____ Phone_____Fax _____
Who is to receive the information	☐ Des Moines University **OR** ☐ Name _____ Address _____ City, State, Zip _____ Phone_____Fax _____
What information should be sent	☐ Entire medical record – medical documentation, lab, test, & radiology results ☐ Records dating from_____ to _____ ☐ Records from a specific provider or clinic _____ ☐ Immunizations ☐ Billing Statement ☐ Other_____ ☐ Radiology Images
Purpose of request	☐ Transferring medical care to another health care provider ☐ Other

TURN OVER TO COMPLETE. AUTHORIZATION IS NOT COMPLETE WITHOUT SIGNATURE

I specifically authorize the release of records that may include protected information

Yes or No must be checked for each of the following:

☐ Yes ☐ No Mental Health

☐ Yes ☐ No HIV-related information including AIDS and related testing

☐ Yes ☐ No Substance abuse treatment (Alcohol/Drug)

I prefer the information sent in the following format:

☐ Paper ☐ Electronic – CD / DVD supplied by DMU, no personal devices accepted.

Delivery Method

☐ Mail ☐ Pick-up ☐ Fax ☐ Email – Email is restricted by size. It is the responsibility of the patient/legal representative to understand unencrypted email is not protected by federal privacy regulations (HIPAA). DMU is not held accountable once the transmission is sent. Email is only sent to the patient/legal representative.

Email address _____

Re-disclosure: I understand the information used and/or disclosed per this authorization may no longer be protected by federal privacy law (HIPAA) and the recipient of my health information may potentially re-disclose it. However, Federal law (42 CRF Part 2) for Alcohol/drug abuse, and State Law (IA Code ch 228 & 141) for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, without the specific written consent of the patient, or as otherwise permitted by such law and /or regulations. A general authorization for the release of medical information is not sufficient for these purposes.

Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Minimum necessary rules are followed for all disclosures. Civil and criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/Aids information.

Signature of patient or legal representative _____

Date _____

Relationship to patient, if signed by legal representative _____

For office use only – Patient Identification Verified Yes ____