IOWA DIGESTIVE DISEASE CENTER
GASTROENTEROLOGY, HEPATOLOGY, DIAGNOSTIC AND THERAPEUTIC ENDOSCOPY

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT IDENTIFICATION:

Name:_____ DOB:__/__/____ SSN:_____ Chart #:_____

Street Address:_____ City/State/Zip:_____

Home Phone:_____ Alternative Phone: [work/cell] _____

RELEASING PROVIDER:

Provider Name:_____ Practice Name:_____

Address:_____ City:_____ State/Zip:_____

Telephone:_____ Fax:_____ Office Representative:_____

RECEIVING PROVIDER:

Provider Name:_____ Practice Name:_____

Address:_____ City:_____ State/Zip:_____

Telephone:_____ Fax:_____ Office Representative:_____

INFORMATION:

- ☐ Complete Records *(Excluding mental health, Alcohol / Drugs, and HIV records)*
- ☐ Laboratory Reports
- ☐ X-Ray Reports
- ☐ Other: _____
- ☐ Procedure / Operative / Pathology Reports
  Check applicable item for the reports/pathology on:
  - _____ Colonoscopy
  - _____ EGD
  - _____ Flex Sigmoidoscopy
  - _____ BRAVO / Capsule

PURPOSE OF RELEASE:

- ☐ Transferring Medical Care
- ☐ Insurance Coverage
- ☐ At Request of Patient
- ☐ Moving
- ☐ Case Coordination
- ☐ Other:_____

I SPECIFICALLY AUTHORIZE THE RELEASE OF DATA AND INFORMATION RELATING TO:

☐ Substance Abuse (Alcohol / Drug) ☐ HIV Related Information ☐ Mental Health

IDDC does not require completion of this form as a condition of evaluation or treatment.

I understand that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed, it may no longer be protected by federal privacy regulations.

This authorization is **effective for 365 days** 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 Iowa Digestive Disease Center. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Iowa Digestive Disease Center.

Signature of Patient or Legal Representative:_____ Date:_____

Relationship to Patient If not signed by Patient:_____ Witness:_____

PROHIBITION OF REDISCLOSURE: This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by the federal law for alcohol/drug abuse treatment records or by state law for mental health records, federal requirements (42 CFR Part 2) and state requirements prohibit further disclosure 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 or other information is not sufficient these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse treatment or mental health information. In compliance with HIPPA regulations, the authorization submitted does not state the entity ability or inability to condition treatment, payment, enrollment, or eligibility for benefits.

#13 PT-Auth to Release -Receive Med Info