REGIONAL HEALTH SERVICES OF HOWARD COUNTY - ROI FORM

Hospital Services	Cresco Clinic	Lime Springs Clinic
235 8th Ave W	321 8th Ave W	101 W Main
Cresco, IA 52136	Cresco, IA 52136	Lime Springs, IA 52155
563-547-2101	563-547-2022	563-566-2243

NAME: _____

DATE OF BIRTH: _____ MEDICAL RECORD #: _____

ADDRESS: _____

I. GENERAL RELEASE I authorize:

Release from (Name): _____ Release to (Name): _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone/Fax: _____ Phone/Fax: _____

Service Dates (approximate)	**Information Need By (Specify Date)**

☐ History & Physical ☐ EKG ☐ Laboratory Reports ☐ ER Notes

☐ Immunization Records ☐ Pathology Reports ☐ Radiology Reports ☐ Hospital Discharge Summary

☐ Clinic Office Visit ☐ Operative Reports ☐ Radiology Images Billing ☐ Statements

☐ Other _____

_____

I. SPECIAL RELEASE - MINORS MUST SIGN THE CONSENT WHEN RELEASING THE INFORMATION BELOW.

I specifically authorize the release of:

☐ **Mental Health records** **Initial** _____

☐ **Substance Abuse records** **Initial** _____

☐ **HIV/AIDS information** **Initial** _____

Patient/Representative Signature: _____ **Date:** _____

Representative's Relationship to the Patient: _____ **Witness:** _____

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 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. **If mental health information is being disclosed, I acknowledge receipt of a copy of this Authorization.**

Please check one: ☐ Mail Records Fax ☐ Records (provide fax number above)

☐ Will Pick Up Records At (Check box to right) ☐ Clinic ☐ Hospital ☐ X-Ray

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Health Information Department. 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 as a patient I have the right to access my records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I understand that RHSHC and Affiliated Clinics/Hospitals may not require completion of this for as a condition of treatement. 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. This authorization will expire on the following date, event, or condition _____. **If I fail to specify, this authorization will expire in twelve (12) months.** A photocopy of this signed authorization shall be as effective as the original.

_____ _____

Patient / Representative Signature **Date**

_____ _____

Representative's Relationship to the Patient **Witness**

RHSHC use only: ID verified by _____ Date Printed: _____ Date completed: _____ Initials: _____