AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

Please complete all sections, sign and date. Photocopy of signed original is as effective as original. There may a fee for copies of records.

WAVERLY HEALTH CENTER
312 Ninth Street SW – Waverly, Iowa 50677
(319) 352-4930 – www.WaverlyHealthCenter.org

Patient Name: _____ **Date of Birth:** _____
Last First MI Previous Name

Address: _____ **Phone Number:** _____
Address/City/State/ ZIP

Information From:

_____
Name of person and/or facility

_____
Address

_____
City, State, Zip

_____
Telephone Number

_____ _____
Fax Number Attention To

Information To:

_____
Name of person and/or facility

_____
Address

_____
City, State, Zip

_____
Telephone Number

_____ _____
Fax Number Attention To

Reason for Request: ☐ Referral for care ☐ Transfer of care ☐ Moving out of area ☐ Legal ☐ Insurance

☐ Other (specify) _____

Type of Information to be Disclosed:

☐ Last 2 years of records unless otherwise specified: _____ to _____
(Month/year) (Month/year)

☐ Records pertaining to date/conditions: _____

☐ Clinic records (specify clinic, date) _____

☐ Billing info (specify date) _____

Type of Access Requested: ☐ Mail ☐ E-mail ☐ Fax (limited 40 pages) ☐ Other (specify) _____

☐ Secure email: _____
Provide E-mail address

☐ If you want your records sent in an un-encrypted e-mail and you understand and accept the risk of your PHI sent in this unprotected manner, please initial here: _____ _____
Initial **Provide E-mail address**

*****I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance use, mental health, AIDS-related information, and/or genetic-related information. I authorize the release of confidential information relating to the following categories, unless I specifically deny their release below:**

Check any category **NOT** to be released:

☐ HIV- or AIDS-Related Information (includes testing for)

☐ Substance Use or Abuse (includes drugs or alcohol)

☐ Mental Health Treatment (includes depression, anxiety, etc.)

☐ Genetic testing/information (refers to genetic testing to screen for a possible future health issue)

Please sign on page 2 of 2 (on back)

Expiration Date: This authorization is valid for 1 year from date of signature or until _____ (specific date up to 2 years).

Please read the following statements carefully:

- I give Waverly Health Center or physician/licensed practitioner listed permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked.
- I understand that I may cancel or revoke this authorization at any time by sending a written notice to Waverly Health Center. Upon receipt of the written revocation, the Health Information Management Department will stop using or disclosing the information, except to the extent that it has already taken action in reliance on the authorization.
- Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless I am receiving research-related treatment, or the sole purpose for creating the PHI is to disclose to a third-party such as my employer (e.g., fitness to return to work) or school (e.g., athletic participation).
- I understand that authorizing the disclosure of this health information is voluntary. Signing this form is not required.
- I have the right to inspect the information to be disclosed.
- I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information may be re-disclosed and is no longer protected by the regulations.
- Copies of my records may be obtained with reasonable notice and payment of copying cost, if applicable.
- The statements made in this authorization are binding, controlling and I understand that they take precedence over statements in the organization Notice of Privacy Practices.

_____ _____ _____

Signature of Patient/Personal Representative | Date of Birth | Date

If signed by patient's representative, please PRINT representative's name and describe his/her authority.

_____ **Authority:** ☐ Parent of Minor ☐ Legal Guardian

Representative's name ☐ Power of Attorney for Health Care

☐ Other _____

Obtain HCPOA or Court Appointment Document, if necessary, and attach _____

Initials /Date

Notice to Receiving Person/Agency/Entity: Federal and/or State law specifically require that any disclosure or re-disclosure of substance abuse, mental health, or HIV-related information must be accompanied by the following written statement: 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 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. See also Chapter 228 and Chapter 141(A) of the Iowa Code and other applicable laws.

Internal Use Only:
(Document PHI disclosed, date of disclosure, and by whom.)

Released by/Department: _____ _____ ☐ Identification verified, if applicable

Initials/Department **Date/Time**