CHI Health

CS0020

MEDICAL RECORDS AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Please mark where records are being disclosed from:

☐ Alegent Creighton Clinic ☐ Bergan Mercy ☐ Missouri Valley ☐ Creighton University Medical Center
☐ Immanuel ☐ Lakeside ☐ Schuyler ☐ Mercy Corning
☐ Mercy Council Bluffs ☐ Midlands ☐ Plainview ☐ Psychiatric Associates
☐ Other_____ Contact number at Facility if known_____

I hereby authorize the above checked Facility(s) to disclose the following information from the records of:

Patient Name	Patient Number
Address	Date of Birth
City/State/ZIP + 4	Phone ( )

An authorized Facility medical records custodian or person(s) identified as responsible for these records will process this disclosure. Information to be disclosed from the above checked Facility(s) includes *(check all that apply):*

☐ Chemical dependency reports ☐ Discharge summary ☐ Educational/school reports ☐ Lab
☐ Mental Health evaluations ☐ History and Physical ☐ Rehab notes ☐ X-ray
☐ Clinic progress notes ☐ Name and diagnosis only ☐ All medical records associated with my treatment
☐ Other_____

I understand that this **will include** information relating to *(check if applicable):*

☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
☐ Mental Health Information (Iowa only: Please note that individuals are entitled to inspect materials to be disclosed)
☐ Mental Health Joint Counseling Sessions (Please note that an Authorization Form must be obtained from all individuals present during such sessions.)
☐ Psychotherapy notes (A separate Authorization Form must be signed for disclosure of psychotherapy notes)
☐ Treatment for alcohol and/or drug abuse

I understand that this will cover information related to all dates of service unless I specify otherwise below:
Covering the period(s) of care: from _____ to_____

This information will be disclosed to (**please be specific including individual and/or Facility name and address**):

_____

_____

_____

for the purpose of _____
If no purpose is stated, then the purpose of the disclosure will be "at my request".

I understand this Authorization may be revoked at any time, except to the extent that action has already been taken in reliance on this Authorization. I understand that if I wish to revoke this Authorization, I must do so in writing and present my written revocation to the medical records department or custodian with whom the original Authorization was submitted.

Unless otherwise revoked, this Authorization will expire on the following date, event, or condition _____

If I fail to specify an expiration date, event or condition, this Authorization will expire twelve (12) months from the date below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need not sign this Authorization in order to receive treatment. CHI Health will not condition any treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality laws. If I have questions about disclosure of my health information, I can contact the CHI Health Privacy Office at (402) 717-1730.

☐ This information has been disclosed to you from records which may be 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 to 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Patient		Date
Signature of Parent/Legal Guardian if Patient is a Minor/Power of Attorney/Guardian	Relationship to Patient	Date