WAVERLY HEALTH CENTER
312 Ninth Street SW – Waverly, Iowa 50677
(319) 352-4120 – www.WaverlyHealthCenter.org

Authorization to Disclose Protected Health Information

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

Information From:

_____
Name of facility/provider

_____
Address

_____
City, State, Zip

_____
Telephone/Fax

Information To:

_____
Name of facility/provider

_____
Address

_____
City, State, Zip

_____
Telephone/Fax

I give permission to the provider listed above to give the following information from my health record to the organization above for the purpose of: □ Medical Care □ Legal Use □ Insurance □ Other (specify) _____

Please check the information to be shared and include dates where indicated:

□ Most recent History and Physical □ Most recent discharge summary □ Most recent Emergency Room report

□ Laboratory (specify type or date) _____ □ Consultation report(s) (specify type) _____

□ Test results (i.e. EKG, PFT, etc. specify type and date) _____ □ Billing information (specify date) _____

□ X-ray and imaging reports and/or films (specify type or date) _____

□ Clinic records _____

□ Other _____

NOTE: If the information includes mental health treatment, substance abuse treatment, or HIV-related information, it will not be released unless you agree to the release on the reverse side of this form.

Affirmation of Release:
I give Waverly Health Center or the provider listed above 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 this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing in the Health Information Management Department. Copies of my records may be obtained with reasonable notice and payment of copying cost. 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 described above may be redisclosed and no longer protected by the regulations.

_____ _____
Signature of Patient/Personal Representative Date Signed

_____
Relationship to Patient

Information disclosed by:

_____

Specific Authorization for Release of Information Protected by State or Federal Law

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and or HIV-related information. I specifically authorize the release of information relating to:

- ☐ Acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV) infection
- ☐ Mental health treatment
- ☐ Substance abuse treatment

_____ _____

Signature of Patient/Personal Representative Date Signed

_____

Relationship to Patient

Federal and/or State law specifically require that any disclosure or redisclosure 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 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.