Form 1989 Hospital #: _______________

ADMIN – CONSENT TO RELEASE OF INFORMATION AND RIGHT OF ACCESS REQUEST

University of Iowa Health Care (UIHC)

Health Information Management Department, Release of Information Office, 200 Hawkins Dr., Iowa City, IA 52242

Telephone: 319-356-1719; Fax: 319-356-3079 or 319-353-7944; Email: him-consentform@uiowa.edu

Patient legal name: ______________________ **Birth date:** ______________

Complete mailing address: ______________________

List any previous names (maiden, married, legal changes): ______________________

Send UIHC information to: ___ Myself at the address above unless noted below

Name and/or facility: Iowa Department for the Blind

Complete mailing address: 524 Fourth Street, Des Moines, IA 50309-2364

Format of information to be released:

___ Electronic (circle): CD / USB drive / MyChart ___ Verbal ___ To file only ___ Paper

___ Fax: 515-242-5781 ___ Email: ______________________

(Email is not a secure means of communication)

Information to be released (will be from the previous two years unless specified below)**:**

___ Summary of record ___ Immunization record ___ Pathology slides
___ Billing information ___ Laboratory results ___ Psychotherapy notes
___ Discharge notes ___ Office visit notes ___ Radiology images
___ Emergency notes ___ Operative/Procedure reports ___ Radiology reports
___ History and physical ___ Pathology reports ___ Test results (EKG, PFT, EMG, etc.)
X Other: Eye report including best corrected visual acuity, peripherals, diagnosis and prognosis

Date(s): ____________ to ____________ **and/or Department/Provider:** ______________________

Reason for release:

___ Rehab/disability ___ Insurance ___ Legal ___ Personal ___ Medical ___ Other: ______________

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge 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. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address. I have been offered a copy of this authorization. I understand there may be a charge for this information.

UIHC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release **(*check* any category *not* to be released)**.

___ Substance abuse* ___ Mental health ___ HIV-related information ___ Genetic tests/info**

*Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). **Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement allows release of past and future UIHC information and will expire 2 years from the date of signature, or as indicated (specify number of days or months) ______________________ unless cancelled by the patient/guardian. UIHC will respond to this request within 30 days of receipt. If additional time is required, you will be notified of the extension.

Signature: ______________________ **Date:** ______________

(Patient or person legally authorized to consent for patient)

______________________ ______________________

(Printed name of legally authorized person signing) (Relationship of legally authorized person)

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(Witness signature, only required when patient or person legally authorized is physically unable to sign)

Internal use only: _____ Initial if form has been processed and scanned into Epic under the *HIM ROI Authorization* document type.

Revised: 8-2021