CONSENT FOR RELEASE OF INFORMATION

MRN. #______________

ALL CARE HEALTH CENTER

902 South 6th Street
Council Bluffs, IA 51501
Phone : 712-325-1990
Fax :712-325-0288

Please PRINT (except signature) and provide complete information in each section.

* **Patient's Legal Name** ______________________________ * **Birth Date** ____________________

Address ______________________________ Phone No. ____________________

By signing this form, I am allowing * ACHC to RELEASE or RECEIVE (circle one) medical information via:
Mail: __ Pick Up: __ Fax: ____ Verbal: _____ Electronic Device: _____ concerning the above named patient.

Circle one:

* TO/FROM ______________________________ PHONE ________________ FAX ________________

Person and /Or Institution

____

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Note: if this notice accompanies a disclosure of information concerning a patient in alcohol and drug treatment, made to you by the consent of such patient, the following will apply. This information has been disclosed to you from records that are protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of information in this record that identified 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 C.F.R. 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 client.

* **Check the information to be disclosed (include dates if known):** _____ Minimum necessary, or specify as follows:
* ___ Medication list ____ Allergy list ___ Immunization record _____ Problem List (Pt. Summary list)

__ History and Physical, specify clinic or date ______________________________
__ Discharge summary, specify clinic or date ______________________________
__ Laboratory results, specify type or date ______________________________
__ X-ray and imaging reports, specify type or date ______________________________
__ Consultation reports, specify doctor or clinic ______________________________
__ Test results (e.g. EKG, PFT, etc.), specify type or date ______________________________
__ Billing Information, specify ______________________________
__ other, specify ______________________________

Please indicate the reason for release, and provide a date by which the info is needed: ____________________
Insurance___ 2nd opinion ___ Rehab/disability___ Personal file___ Moving out of area___ Legal___ Other medical care _____ Transfer of care ______ **If transferring care,** may we confidentially discuss with you? YES ___ NO___

If yes, please indicate the best time and telephone number to reach you: ______________________________

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Director of Health Information Management, All Care Health Center, 902 South 6th Street, Council Bluffs IA 51501.

ACHC 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 **will not** include information in the following categories, unless I specifically request the release. *Initial* any category you request **to be released**.

Substance Use:________ Mental Health: _________ HIV-related information: _______ *Genetic tests/info_______

*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 will expire one year from the date of signature, or as indicated (specify number of days or months) _______ unless cancelled by the patient/guardian.

* ______________________________ * ______________________________
Signature of Patient or Legal Guardian Date

______________________________ ______________________________
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

______________________________ ______________________________
Relationship, if Not the Patient Witness Signature