UNIVERSITY OF IOWA HEALTH CARE MEDICAL CENTER
DOWNTOWN (UIHC - Medical Center Downtown)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

#9-19 (02/2024 updated)
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Health Information Management, 500 E. Market St., Iowa City, IA 52245
Phone: 319-339-3609; Fax: 319-339-3785; Email: Mercyic@Scanstat.com

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Last First M.I. mm/dd/yyyy

Mailing Address: _____
Street City State/Zip

Phone Number: _____ Email Address: _____

RELEASE FROM
(Check all that apply)

☐ **UIHC-Medical Center Downtown**	☐ **UIHC-Medical Center**	☐ **Corridor OB GYN**
(Formerly Mercy Hospital)	**(Formerly Mercy Clinics)**	2769 Heartland Dr. Ste. 201
500 E. Market St.	_____	Coralville, IA 52241
Iowa City, IA 52245	Specify location(s) or write "All"	

RELEASE TO SELF
or
RELEASE TO OTHERS
☐ Verbal Only

☐ Patient's Home Address (address listed above) or ☐ Patient's Email Address (email listed above)

Name/Organization: _____ Phone Number: _____

Send via USPS to (mailing address): _____

Fax to : _____ Send via Secure Email to: _____

INFORMATION REQUESTED
(Check all that apply)

For date(s) of service: ____/____/____ to ____/____/____

☐ Abstract Summary	☐ Operative Report	☐ Consultation Report	☐ Itemized Billing Statement
☐ History and Physical Report	☐ Pathology Report	☐ Medication/Allergy List	☐ Radiology Report
☐ Emergency Room Report	☐ Laboratory Report	☐ Clinic Visit Note	☐ Radiology Images (Send to RAD)
☐ Discharge Summary Report	☐ Other: (Specify)_____		

****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY STATE OR FEDERAL LAW****

Initial any category NOT to be released

_____ Acquired immunologic syndrome (AIDS) or human immunodeficiency virus (HIV)
_____ Alcohol and drug abuse treatment
_____ Behavioral or mental health services

PURPOSE FOR DISCLOSURE

☐ Patient Care (Medical)
☐ Insurance Claim
☐ Other: (Specify): _____
☐ Personal Use (Fees May Apply)
☐ Legal Review (Fees Apply)

TIME LIMIT

I understand that I may cancel (revoke) this authorization at any time by sending a written notice to University of Iowa Health Care Medical Center Downtown's Health Information (Medical Records) department and that my cancellation will take effect when the written notice is received and it will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one year from the date of signature except as specified.

(Specify expiration date, event, or condition:_____.)

DISCLOSURE INFORMATION

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations unless otherwise prohibited from re-disclosure under other federal and/or state laws or regulations.

FAXING/EMAIL AUTHORIZATION

By entering fax or email information in the form above, I authorize electronic transmission (fax/secure email) of my medical records. If any portion of the fax/email is received by an inappropriate third party in error or by exploit, I release University of Iowa Health Care Medical Center, its affiliates, its physicians and staff of any and all liability relating to the disclosure of said records. Records may be provided in electronic form on a secure disk. Paper records are available upon request.

SIGNATURE AND DATE

_____ _____
Signature (Patient or Legal Representative) Date

_____ _____
Relationship, if not patient Witness (If patient or authorized individual is unable to sign)