AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION (Please print clearly)	NAME:________________ DATE OF BIRTH: __________ Address:________________ Day Phone: __________ City: State Zip:
Releasing Provider – (*Who* has the information you want released?) **Please list the specific Hospital and/or clinic or checkmark the location or locations. Only what is indicated will be released.**	NAME: ________________ Address:________________ Day Phone: __________ City:________________ State__________ Zip: __________ ☐ Boone County Family Medicine North ☐ Boone County Family Medicine South ☐ Boone County Family Medicine Ogden ☐ Madrid Family Practice ☐ Ogden Rehab ☐ Boone County Comprehensive Specialty Clinic ☐ Walk-In Clinic ☐ Boone County Hospital
Receiving Party (*Where* do you want the information sent? *Who* may have the information?)	NAME:________________ Attention to: __________ Address:________________ Day Phone: __________ City:________________ State__________ Zip: __________ Fax Number (URGENT PATIENT CARE ONLY) ________________
Release Instructions (*How* do you want the information?)	Release Method / Format requested: (check only one) ☐ *Paper* ☐ *CD* ☐ *USB* ☐ *Fax* (patient care only or less than 35 pages) ☐ *Other*________________
Information to be Released (*What* do you want sent or released? Check the appropriate box.)	Only records types checked below: ☐ Discharge summary/note ☐ Radiology reports ☐ Emergency record(s) ☐ Medication records ☐ History & physical exam ☐ Rehab records (PT/OT/ST) ☐ Immunization/allergy record ☐ Operative report ☐ Laboratory reports ☐ Pathology reports ☐ Progress notes/clinic notes ☐ Billing Records ☐ Tech Services (EKG, PFT, Echocardiogram, Stress Test) ☐ Other records specify record type(s) __________ Disclose only records related to following: Date(s) of service:__________ Injury or Illness: __________ Unless Date of Services is further specified below only the last 2 years will be sent. Dates of Services From: __________ To: __________
Specific Authorization (Check mark and initial areas that apply)	_____ ☐ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency (HIV) infection _____ ☐ Behavioral health services/psychiatric care _____ ☐ Treatment for alcohol and/or drug abuse _____ ☐ Genetic Information
Purpose of Release (*Why* is it needed?)	☐ Continuing care ☐ Transfer of care ☐ Insurance application* ☐ Personal use or review * ☐ Other* ________________ * Fees may be charged in accordance with Federal Rule 45 C.F. R. §164.524

- This authorization lasts for one year after the date you sign it.
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. Cancellation will take effect on the day it is received in writing by Boone County Hospital.
- BCH will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- BCH records may include records that it received from other organizations. If these records have been used by BCH and filed in the record BCH maintains about you, these records may be released with your BCH records.
- BCH cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release BCH from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

______________________	__________	______________________
Patient/Legal Guardian Signature	Date	Authority to act on behalf of patient (attach document)

Directions for Completion of Form

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for).

Releasing Provider: Identify which Boone County Hospital or Clinic you are seeking information from (or to be sent to). **Please be specific** in your request. You may checkmark the specific location or multiple locations that you are wanting records from.

Receiving Party: Identify the full name/business, address, phone and contact information with the name of the individual who is *to receive* the information.

Please note: It is Boone County Hospital policy will fax or email patient information only for direct patient care requirements (e.g. to a doctor or clinic). BCH may fax other requests for information if only under 35 pages. Typically requests for information are processed and sent to the recipient within 7 – 10 business days. We may take up to 30 days according to federal law to release records.

Information to Be Released: This section gives us the instructions for what information you want released.
Please select the location that you want records released from. You may choose more than one location.
Please also select the type of records you want released. You may choose more than one type of record.
It is very helpful if you identify the date or range of dates being requested. If no dates are requested then the last 2 years will be released.

Specific Authorization: Specific authorization is for protected health information that contains information related to Mental Health, HIV, Substance Abuse. Records containing this information has additional protections by state or federal law. You must specific check mark and initial those areas that apply.

Release Instructions: This tells us how you would like your information delivered. We can print the documents or create a CD or USB. If you wish to view information prior to selection of documents, please identify this on the authorization form and we will contact you to set up a viewing appointment. Please note that viewing appointments are done at Boone County Hospital.

Purpose of Request: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months.

Contact Information for Patient Record Copies

Health Information/ROI
Boone County Hospital
1015 Union St.
Boone, IA 50036
Phone: (515) 433-8281
Fax: (515) 433-8903