



Authorization to Disclose Health Care Information

Thielen Student Health Center (TSHC)
Iowa State University
Ames, Iowa 50011-2260
Phone: 515-294-2614
Fax: 515 294 5457

PATIENT INFORMATION:

Patient Name (please print) _____ Student I.D. # _____

Former Name (if any) _____ Birth Date _____

Address _____

Phone # () _____ Cell Phone # () _____ E-mail _____

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH CARE INFORMATION AS INDICATED:

Release From: _____ Send To: (Please provide complete address) _____

Method for sending Information (circle one): **Mail** **Hold for Pick Up** **Fax** **Date Needed:** _____

Medical Information Requested:

- Complete Records
 - Lab (s)
 - X-ray Reports
 - Gyn/Pap/Depo
 - Immunization
 - Prenatal: OB Transfer 20 wk Data
- Other _____

Reason for Release:

- To update my regular doctor (provider)
- I have been referred to another doctor
- I want / need a second opinion
- I am changing doctors (provider)
- Dissatisfaction with care
- I am moving
- Talk with Parent/Guardian
- Other _____

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

NOTE: YOU MUST CHECK (X) YES or NO

I specifically authorize the release of data and information relating to:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Substance Abuse (alcohol/drug abuse) |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Mental Health (ADD, depression, anxiety, testing) |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. HIV-related Information (AIDS related testing) |

Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health, or AIDS-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.

See Also Chapter 228 of the Iowa Code (Mental Health) and Section 141A.9 of the Iowa Code (AIDS) and other applicable confidentiality laws.

I UNDERSTAND THAT:

- This authorization will automatically expire one year from the date of my signature or on ___/___/20__.
- This authorization may be revoked at any time by notifying TSHC in writing except to the extent that action has been taken in reliance on it.
- I can request an accounting of disclosed information by writing to the ISU Health Information Privacy Office.
- My refusal to sign, or revocation of, this authorization will not affect my ability to obtain health care services from TSHC
- The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy rules.

Signature of patient or legal guardian (patients over 18 must sign own release) _____ Date _____

Relationship and authority, if not the Patient _____ Witness _____

THERE MAY BE A FEE ASSOCIATED WITH THE COPYING OF RECORDS

FOR INTERNAL USE ONLY Reviewed and approved by: Dr. _____ Date: _____ Sent: _____