ST. ANTHONY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

311 S Clark Street
PO Box 628
Carroll, IA 5141
Phone: (712) 794-5253
Fax: (712) 794-5480

Form 1017
Rev. 07/26

Record Number: _____

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____
(MM/DD/YYYY)

I, the undersigned, do authorize and request _____
(Provider to Release Information)

to release information to: _____
(Name of Person/Provider to Receive Information)

Mailing Address / Street / PO Box: _____

City, State, Postal Zip Code: _____

_____

Check the information to be disclosed:
(Include dates where indicated) Minimum necessary or specify:

☐ **Summary of the Stay** including discharge summary, discharge instruction, history and physical examination, consultation and operative report for the following dates: _____ (MM/DD/YYYY) - _____ (MM/DD/YYYY)

☐ **Clinic notes** - for the following dates: _____ (MM/DD/YYYY) - _____ (MM/DD/YYYY)

☐ **Other,** please specify: _____

Purpose of releasing information: _____

I understand that the records released may contain information related to the following and I authorize its release: **(Please initial by all those that apply.)**

_____ Mental Health _____ Drug & Alcohol Abuse _____ AIDS / HIV related information

*The following applies: Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). **Disclosure of mental health information may only be made pursuant to the written authorization of an individual or an individual's legal representative, or as otherwise provided in Iowa Code Chapter 228.

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Patient First Name: _____ Patient Last Name: _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to: Director of Health Information, St. Anthony Regional Hospital, PO Box 628, Carroll, IA 51401. The cancellation will not be effective until received by the above.

I understand that any release that was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure and 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 understand that St. Anthony may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated. (Specify number of days or months or date.) _____ or _____
Number of days (MM/DD/YYYY)

_____ _____
Name of Patient or Legal Guardian Signature of Patient or Legal Guardian Date/Time

Mailing Address / Street / PO Box: _____

City, State, Postal Zip Code: _____

Self _____
Relationship if not the patient Witness Signature Date/Time

Expiration Date of Authorization: _____
(MM/DD/YYYY

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