CRESCENT COMMUNITY HEALTH CENTER

1690 Elm Street, Suite 300
Dubuque, Iowa 52001
www.crescentchc.org

Main Line: 563-690-2850
Medical Records Phone: 563-690-2886
Medical Records Fax: 563-588-8088

| *CCHC Staff Use Only* |
|---|
| MRN: |

# Authorization for Release of Protected Health Information

| | | | | |
|---|---|---|---|---|
| **A Patient Information** | **Legal Name** | **Previous Names** | | **Date of Birth** _____/_____/_____ |
| | **Address** | **City** | **State** | **ZIP** |
| **B Who is releasing the information?** | **Name of Facility or Individual** | **Phone** | | **Fax** |
| | **Address** | **City** | **State** | **ZIP** |
| **C Who is receiving the information?** | **Name of Facility or Individual** | **Phone** | | **Fax** |
| | **Address** | **City** | **State** | **ZIP** |

**D Records to be Released or Obtained**

✓ Check all that apply

- ☐ Medical Records
- ☐ Dental Records
- ☐ Brain Health/Mental Health Records
- ☐ Insurance/Billing/Payment Information
- ☐ Lab/Pathology Reports
- ☐ Imaging Reports
- ☐ Visit Summaries
- ☐ Other, please specify: _____

**E State and/or Federal Protected Information**

I understand that information in my health record may include information relating to: Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health/Psychiatric care, treatment of alcohol and/or drug abuse/substance use disorder, and genetic testing/information. My signature authorizes the release of any such information.

**If you DO NOT want any of the above-mentioned information released, please specifically indicate that below:**

_____

**F Purpose of the Request**

✓ Check all that apply

- ☐ Coordination of Care
- ☐ Insurance/Financial Eligibility/Payment
- ☐ Legal Involvement
- ☐ Family Involvement
- ☐ Specialty Referral
- ☐ Personal Use
- ☐ Transfer of Care
- ☐ Other, please specify: _____

**G Delivery of Information**

✓ Check all that apply

**Physical Requests:** ☐ **Pick Up – Paper** ☐ **Pick Up – USB Drive** *(for Dental 3-D Imaging ONLY)* ☐ **Mail**

**Electronic Requests:** ☐ **Fax** ☐ **Encrypted Email** (please list below)

**Other:** ☐ **Verbal and Written Exchange of Information between entities**

Email Address: _____

- This authorization is **effective for ONE year from the date on which it is signed.**
- I understand that I have a right to receive a copy of this authorization.
- I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Crescent Community Health Center.
- ***I understand that I may revoke this authorization at any time***, except to the extent that action had been taken in reliance on it. In any event, this authorization automatically expires upon a formal and effective revocation that ***must be given in writing*** to **Medical Records** at **Crescent Community Health Center, 1690 Elm St, Ste 300, Dubuque, IA 52001.**
- I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- **I understand this authorization is voluntary.**
- If I transfer out of Crescent Community Health Center (CCHC), I will allow CCHC to continue to obtain data for reporting purposes.

### Prohibition of Redisclosure

This form does not authorize disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for substance use or by state law for mental health records, and HIV/AIDS test results, federal requirements (42 C.F.R. Part 2, HIPAA 45 C.F.R. Parts 160 & 164) and state requirements (Iowa Code ch.228 & ch.141A) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. Recipients of this information could incur civil and/ or criminal penalties for the unauthorized disclosure of substance use disorder, mental health, and/or HIV/AIDS test results information; substance use disorder information is restricted from being used to criminally investigate or prosecute the patient.

**H Authorization**

**By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form.**

**Signature of Patient:** _____ **Date:** _____/_____/_____

**Printed name of Legal Representative/Guardian:** _____

**Signature of Legal Representative/Guardian:** _____ **Date:** _____/_____/_____

**Relationship to Patient:** _____ **Witness Signature:** _____