Crescent Community HEALTH CENTER

1690 Elm Street Ste 300
Dubuque, Iowa 52001
Phone: (563) 690-2886 Fax: (563) 588-8088
www.crescentchc.org

External Authorization for Release of Protected Health Information

Legal Name:_____ Date of Birth:_____

Previous Name(s):_____ MRN/PID:_____

I (above named) authorize Crescent Community Health Center and the following entity:

_____

(Name of Organization or Person) (Phone Number/Email/Fax of Organization or Person)

_____

(Address of Organization or Person) (City) (State/Zip)

To communicate, release, and/or obtain by oral, written, and/or electronic means the following information related to my medical, dental, and/or brain health care/records:

☐ All information/No Restrictions ☐ Screenings/Assessments/Recommendations ☐ Lab/Test Results
☐ Appointments/Scheduling/Attendance ☐ Insurance/Billing/Payment Information ☐ Visit Summaries
☐ Dental Records ☐ Other (Specify):_____

I specifically authorize the release of information protected by State and/or Federal Law related to: INITIAL BELOW

_____ Mental Health _____ Substance Use _____ HIV/AIDS

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

Purpose of Request:

☐ Coordination or Monitoring of Services ☐ Legal Involvement ☐ Specialty Referral
☐ Insurance or Financial Eligibility or Payment ☐ Family Involvement ☐ Transfer of Care
☐ Other (Specify):_____

AUTHORIZATION

- This authorization is **effective for ONE year from the date on which it is signed.**
- *I understand that I may revoke this authorization at any time,* except to the extent that action has 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 the **Patient Experience Manager** at **Crescent Community Health Center, 1690 Elm St, Ste 300, Dubuque, IA 52001**.
- 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 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.

_____ _____ _____
Patient Signature Patient Printed Name Witness Signature

_____ _____ _____ _____
Parent/Legal Guardian Signature Parent/Legal Guardian Printed Name Relationship to Patient Date

FOR CCHC USE ONLY:

☐ Receive Records (Incoming) ☐ Send Records (Outgoing) ☐ Save to Chart (No records being sent/received) ☐ Spreadsheet ☐ Fax ☐ Mail

Date records received: _____ Records Received by: _____ Date Records sent: _____ Records sent by: _____