Authorization for Use and Disclosure of Protected Health Information

I, as the patient or patient's legal representative voluntarily consent to, and authorize, Cedar County Public Health to use or disclose health information during the term of this Authorization to the recipient(s) that I have identified below.

Patient Information:
Name ______________________________ Date of birth ______________
Street address ____
City ______________________ State ______ Zip __________
Phone number ______________________

I authorize my health care information to be released to the following recipient(s):
Name: ____
Street address ______________________________ City ______________
State ______ Zip ________ Phone number ______________________

Name: ____
Street address ______________________________ City ______________
State ______ Zip ________ Phone number ______________________

Name: ____
Street address ______________________________ City ______________
State ______ Zip ________ Phone number ______________________

Purpose of Release
☐ Transferring medical care ☐ Insurance coverage ☐ Case coordination/referral
☐ Moving ☐ Legal purposes ☐ Request by patient
☐ Other: ____

Information to be disclosed:
I authorize the release of the following health information: (check the applicable box below)
☐ Billing Records ☐ Laboratory test results ☐ Discharge Summary ☐ History & Physical
☐ Complete Record ☐ Immunizations ☐ Other:
____.

I understand that information to be released may include material that is protected by Federal and/or State law concerning mental health, substance abuse treatment, AIDS–related information and genetics unless I specifically deny the release by initialing the category below:

Please initial beside any category you do NOT want to be released. Substance abuse (drug or alcohol) ______
Genetics ______ Mental health information ______ AIDS–related information, diagnosis, & test results ______

Please continue to reverse side

Public Health
Prevent. Promote. Protect.

AUTHORIZATION VALID FOR: (if no selection is made, this authorization is valid for this request only)

☐ This request only

☐ One year from the date of this authorization OR (insert date): _______________ – this authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request and for records of any future treatment of the type described above until (insert date): ______

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that: signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation, or quality of my treatment at Cedar County Public Health. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Cedar County Public Health at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

I may contact Cedar County Chief Public Health for answers to my questions about the privacy of my health information at Cedar County Public Health, (400 Cedar Street, Tipton, Iowa 52772), or by phone at (563.886.2226).

Legal Representative Information (If different from Patient):

Name ______________________________

Street address ____

City ______________________________ State _______ Zip ___________

Phone number ____

Printed name of Patient or Legal Representative:

Signature of Patient or Legal Representative: Date:

FOR OFFICE USE ONLY			
Application received date		Identity of individual verified	YES/NO

Individual Record Number:

Comments: ____
____
____

Staff's Name and Signature: ____

Date: ________________

Date Entered into Nightingale: ______________________