

**Request of Information for Authorization**

**Patient's Legal Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

By signing this form, I am allowing the Facility/Organization listed below to release information to Washington County Hospital and Clinics (WCHC).

**Releasing Information From:** \_\_\_\_\_ **Patient Telephone Number** \_\_\_\_\_

\_\_\_\_\_  
Name of Institution who will release information

\_\_\_\_\_  
Complete Mailing Address/Street/P.O. Box \_\_\_\_\_ City, State, Zip Code

\_\_\_\_\_  
Telephone Number \_\_\_\_\_ Fax Number

**Releasing Information To:**

Washington County Hospital and Clinics  
400 E. Polk St. \_\_\_\_\_ Washington, IA 52353

\_\_\_\_\_  
Complete Mailing Address/Street/P.O. Box \_\_\_\_\_ City, State, Zip Code

\_\_\_\_\_  
Telephone Number \_\_\_\_\_ Fax Number

**Check the information to be released:**

Date(s) of Service \_\_\_\_\_

Type(s) of Service \_\_\_\_\_

**Purpose of Disclosure:**  At the request of the individual  Medical Care/Transferring Care

\_\_\_\_\_  
This authorization is voluntary. If I choose to cancel this authorization at a later date, I must send a written notification to the Facility/Organization that has released my information. If this authorization is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) 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 at any time by contacting the Facility/Organization that has released my information. I have been offered a copy of this authorization.

\_\_\_\_\_  
WCHC does not require completion of this form as a condition of evaluation or treatment. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release.

**(Initial any category NOT to be released).** \_\_\_\_\_ Substance abuse \_\_\_\_\_ Mental Health \_\_\_\_\_ HIV-related information

\_\_\_\_\_ Genetic Testing Information (Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.)

This authorization will expire one year from the date of signature, unless cancelled by the patient/guardian.

\_\_\_\_\_  
Signature of Patient or Legal Guardian \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_ Relationship, if Not the Patient

**WCHC use only:**

\_\_\_\_\_  
Information released by \_\_\_\_\_ Date \_\_\_\_\_  Patient Offered Copy