WCHC WASHINGTON COUNTY HOSPITAL AND CLINICS
Health Information

Authorization for Release of Information and Right of Access Request

Patient Legal Name: _____ **Date of Birth:** _____

Complete mailing address: _____

List any previous names (maiden, married, legal changes): _____

By signing this form, I am allowing WCHC to release medical information concerning the above-named patient to the person or facility listed below.

I would like this information:

☐ Sent to myself at the address listed above

☐ Released to Person and/or Institution below

_____

Name of Person and/or Institution who will receive information

_____

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

Format of information to be released:

☐ Electronic: CD / USB drive / MyChart ☐ Verbal ☐ To file only ☐ Paper

☐ Fax: _____ ☐ Email: _____

(Email is not a secure means of communication)

Information to be released (will be from the previous two years unless specified below):

☐ Summary of record
☐ Billing information
☐ Discharge notes
☐ Emergency notes
☐ History and physical
☐ Immunization record
☐ Laboratory results
☐ Office visit notes
☐ Operative/Procedure reports
☐ Pathology reports
☐ Pathology slides
☐ Radiology images
☐ Radiology reports
☐ Test results (EKG, PFT, EMG, etc.)
☐ Other: _____

Date(s): _____ to _____ and/or Department/Provider _____

Reason for Release:

☐ Rehab/disability ☐ Insurance ☐ Legal ☐ Personal ☐ Medical ☐ Other: _____

This authorization is voluntary. If I choose to cancel this authorization at a later date, I must send a written notification to the Director of Health Information Management, Washington County Hospital and Clinics, 400 E. Polk, P. O. Box 909, Washington, IA 52353. 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 by contacting the Director of Health Information Management at the above address.

WCHC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release **(check any category not to be released)**.

☐ Substance abuse* ☐ Mental Health ☐ HIV -related information ☐ Genetic testing information**

*Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). **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 allows release of past and future WCHC information and will expire one year from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

Signature: _____ **Date:** _____

(Patient or person legally authorized to consent for patient)

WCHC use only:

_____

Information released by Date Request