Great River Health System

Instructions for Completing the Consent to Release Information

Health Information Management oversees the medical records for hospital and clinic patients. To complete your request and comply with Health Insurance Portability and Accountability Act (HIPAA) regulations, the Consent to Release Information form must be filled out completely. If you have questions after reading these instructions, please call 319-768-1900.

Required information

- **Patient's full name** and **date of birth**
- **Check the box** to identify where (hospital or clinic) information is to be released from. The clinic name must be included to release clinic records.
- **Facility**, **entity**, or **person** to whom the information is to be sent
- **Address** where the information is to be sent
- **Type of information requested** and **date(s) of service**
- **Reason** for request
- Under "Specific Authorization for Release of Information Protected by State of Federal Law," please check and initial boxes you **don't** want released
- **Sign and date** after the "X"
- **Relationship** if you are not the patient:
  - Minors (under 18 years old) – Parents must sign unless law or regulation requires minor's consent.
  - Please call if you have questions about who can sign for another person's records.

Optional Information

- If the record format (paper or electronic) is not chosen, an electronic copy will be provided.
- Include the signing person's address and a witness signature

After completing the form

Mail: Health Information Management – ROI
Great River Health System
1221 S. Gear Avenue
West Burlington, IA 52655

Fax: 319-768-1970

Email: HIMCustomerResourceTeam@grhs.net

Great River Health System Consent to Release Information

(Patient Label)

Patient Full Name [print clearly]:_____ **Date of Birth:**_____

I, the undersigned, do hereby authorize Great River Health System: ☐ Hospital ☐ Home Health Care/Hospice
☐ Clinic:_____ ☐ Center: _____
to disclose and/or deliver to:

_____
(Full Name of Person, Facility or Institution)

_____
(Full Mailing Address, City, State and Zip)

the following minimally necessary information related to the patient's treatment and/or services:

☐ History & Physical ☐ Discharge Summary ☐ Clinical Notes/Progress Notes ☐ Test [lab, imaging, etc.] results
☐ Operative Report ☐ Medications ☐ Treatment/Care Plans ☐ All pertinent
☐ Consultation ☐ Assessments ☐ Discharge Instructions ☐ Emergency Department
☐ Other _____

For dates of service(s) from: _____ to: _____ or ☐ All Dates of Service(s) provided.

☐ Hardcopy/Paper (unless otherwise specified) ☐ Electronic/CD ☐ Secure Portal ☐ Other: _____

The information is requested for the following reason(s): ☐ Continuing or transferring patient care ☐ Insurance
☐ Legal ☐ Personal File ☐ Other - stated here: _____

By completing and submitting this consent the signer understands the following, that:

- this consent may be revoked by sending written notice to: Director, Health Information Management, Great River Health System, 1221 South Gear Avenue, West Burlington, IA 52655, and that any release of information made prior to written revocation, in reliance upon this authorization, shall not constitute a breach of rights to confidentiality;
- disclosure of the information carries with it the potential for unauthorized re-disclosure and once disclosed it may no longer be protected by federal privacy regulations;
- the disclosed information may be reviewed by contacting the Director of Health Information (as above); and that
- GRHS may not require completion of this form as a condition of treatment or payment, however, when the provision of services is solely for the purpose of creating a medical report (protected patient information) for a third party or participation in research related treatment or disclosure of the information for such purposes, refusal to sign this form may result in denial of these services.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:
With this consent I specifically authorize the release of data and information relative to the following, *unless* I indicate the sensitive information that is *NOT* to be included with this release (by checking *and* initialing box(es) below):

❑ _____ Substance Abuse (alcohol/drug abuse) ❑ _____ Mental Health (includes psychological testing)
❑ _____ HIV related information (includes AIDS testing) ❑ _____ Genetic Information

This authorization will automatically expire one year (12 months) from the date of signature or as specified here (number of days or months):_____ unless otherwise revoked (as directed above).

X _____
Signature: Patient or Legal Representative **Date Signed**

_____ _____
Address Relationship if not the patient

_____ _____
City State Zip Witness Name and ❑ ID checked for signer above

Format Sent: ☐ Hardcopy/Paper ☐ Electronic/CD ☐ Secure Portal ☐ Other:_____ Hospital ID#:_____

Sent by:_____ **Date Completed:**_____ **HIM-ROI Tracking Entered Initials:**_____