Instructions for completing the Consent to Release Information

Health Information Management oversees 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
- Facility or person to whom the information is to be sent
- Address where the information needs to be sent
- Type of information requested and dates of service
- Reason for request
- Please check and initial boxes in the Specific Authorization for Release of Information Protected by State or Federal Law that you don’t want released.
- Sign and date after the “X”
- Relationship if you’re not the patient
  - Minors (under 18 years old) – The patient’s legal guardian or parent must sign.
  - Please call if you have questions about who can sign for another person’s records.

**Optional information**
- It is helpful to provide the record source (hospital or clinic) if you know it.
- If the record format (paper or electronic) is not chosen, a paper copy will be printed.
- Include the signing person’s address and a witness’ signature.

**After completing the form**

**Mail:** Health Information Management  
Great River Health Systems  
1221 S. Gear Ave.  
West Burlington, IA  52655

OR

**Fax:** 319-768-1970
Great River Health System
Consent to Release Information

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

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 initiating 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: __________

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