GMHC
Guttenberg Municipal Hospital & Clinics
An Affiliate of MERCYONE

Authorization/Request for Release of Medical Information

Make sure all blanks are filled. Failure to do so could prevent or delay processing.

PLEASE PRINT

PATIENT INFORMATION Please list any previous names used in this space:	Name (First, MI, Last)_____ Address:_____ City:_____State:_____ Zip:_____ Phone:_____ Date of Birth: _____
Guttenberg Municipal Hospital & Cornerstone Family Clinics OR: Hospital Only ❒ Clinics Only ❒ 200 Main St PO Box 550 Guttenberg IA 52052 1-563-252-1121 *VOICE* 1-563-252-5547 *FAX*	**RELEASE TO ❒ or FROM ❒** **OUTSIDE ENTITY/PROVIDER/FACILITY:** Where do you want your records *to be sent* or *requested from*? Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
INFORMATION REQUESTED	❒ Entire Record (past 3 years) ❑Lab, Imaging, EKG ❒ History & Physical ❑Immunization Records ❒Discharge summary ❒Visit notes ❒ Other (specify information to be released): _____ SENSITIVE INFORMATION AUTHORIZATION (Please initial next to applicable fields.) I specifically authorize the release of: ___ Substance Abuse Treatment Records ___ Mental Health Treatment Records ___ HIV/AIDS/HepB Treatment Records
PURPOSE OF RELEASE (Check all that apply)	❒ Continued Care ❒ Insurance ❒ Legal ❒ Transfer of Care ❒ Personal Use ❒ Other_____

EXPIRATION: This authorization is effective for _____ months but **no longer than one year** from the date on which it was signed.

REVOCATION: I understand I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving a written notice.

INSPECTION: I understand I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Guttenberg Municipal Hospital & Clinics.

I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that this authorization is voluntary.

Signature of Patient or Legal Representative:

_____ Date: _____

Relationship to Patient: _____ Witness: _____

PROHIBITION OF REDISCLOSURE

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2) and state requirements (Iowa Code, ch 228). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

OFFICE USE ONLY:

Medical Record #:_____ Date sent: _____ By: _____