

CONSENT FOR RELEASE OF INFORMATION

MRN. # _____

ALL CARE HEALTH CENTER

902 South 6th Street
Council Bluffs, IA 51501
Phone : 712-325-1990
Fax :712-325-0288

Please PRINT (except signature) and provide complete information in each section.

Patient's Legal Name _____ Birth Date _____

Address _____ Phone No. _____

By signing this form, I am allowing ACHC to RELEASE or RECEIVE (circle one) medical information via:
Mail: ___ Pick Up: ___ Fax: ___ Verbal: ___ Electronic Device: ___ concerning the above named patient.

Circle one:
TO/FROM: _____ PHONE _____ FAX _____
Person and /Or Institution _____

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

Note: if this notice accompanies a disclosure of information concerning a patient in alcohol and drug treatment, made to you by the consent of such patient, the following will apply. This information has been disclosed to you from records that are protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of information in this record that identified 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 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Check the information to be disclosed (include dates if known): _____ Minimum necessary, or specify as follows:
___ Medication list ___ Allergy list ___ Immunization record ___ Problem List (Pt. Summary list)

- ___ History and Physical, specify clinic or date _____
___ Discharge summary, specify clinic or date _____
___ Laboratory results, specify type or date _____
___ X-ray and imaging reports, specify type or date _____
___ Consultation reports, specify doctor or clinic _____
___ Test results (e.g. EKG, PFT, etc.), specify type or date _____
___ Billing Information, specify _____
___ other, specify _____

Please indicate the reason for release, and provide a date by which the info is needed: _____
Insurance ___ 2nd opinion ___ Rehab/disability ___ Personal file ___ Moving out of area ___ Legal ___ Other medical care
___ Transfer of care ___ If transferring care, may we confidentially discuss with you? YES ___ NO ___

If yes, please indicate the best time and telephone number to reach you: _____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Director of Health Information Management, All Care Health Center, 902 South 6th Street, Council Bluffs IA 51501.

ACHC 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 will not include information in the following categories, unless I specifically request the release. Initial any category you request to be released.

Substance Use: _____ Mental Health: _____ HIV-related information: _____ *Genetic tests/info _____

*Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement 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 of Patient or Legal Guardian _____ Date _____

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

Relationship, if Not the Patient _____ Witness Signature _____