

Authorization for Release of Patient Information

Patient Information: Name:	Date of Birth: SSN:		
	City, State, Zip:		
	Maiden/Previous Names:		
I authorize Lucas County Health Center and Medical Clinics to RELEASE and/or OBTAIN medical information concerning the above named patient to/from the following:			
Records to/from: Name: Address:	☐ Discharge Summary ☐ Lab or X-ray Results		
City, State, Zip:Phone #:			
Fax #:	Immunization Records Other Entire Medial Records		
The purpose of this use or disclosure is: Continuing Care Transferring Medical Care Patient Request Legal Other			
Expiration Date. This authorization is good until (select one): /			
I understand that I may revoke this authorization in writing at any time by sending a written request to Lucas County Health Center at 1200 North Seventh Street, Chariton, Iowa 50049, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that I may inspect and/or copy the information disclosed. I understand that information disclosed pursuant to this authorization potentially could be subject to re-disclosure by the recipient, and if re-disclosed the information would no longer be protected by the federal privacy rule.			
By signing below, I acknowledge that I have read and I understand this authorization form. I also acknowledge receipt of a copy of this Authorization.			
Signature of Patient or Patient's Authorized Represe	entative Date		
Printed name and authority of patient's legal representative (i.e. Parent/Guardian/Power of Attorney)			
Witness			

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE PATIENT OR PATIENT'S REPRESENTATIVE

NOTE: PHOTOCOPY OF THIS SIGNED AUTHORIZATION SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Specific Authorization for Release. The following information requires special consent by law. Even if you indicate entire medical record on reverse, you must specifically request the following information in order for it to be released (check as appropriate).		
Mental health evaluation/treatment (Note: you have the rig information at any time.)	ht to inspect the disclosed mental health	
☐ Alcohol/Substance Abuse☐ HIV/AIDS		
Signature of Patient or Patient's Authorized Representative	Date	
Printed name and authority of patient's legal representative		
Witness		
Federal and/or State law specifically require that any disclosure of re-	-disclosure of substance abuse, alcohol or	
drug abuse, alcohol or drug, mental health, or AIDS-related informati	ion must be accompanied by the following	
written statement:		
This information has been disclosed to you from records protected by Federal confidentiality rules (42		
CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information		
unless further disclosure is expressly permitted by the written consent of the person to whom it pertains		
or as otherwise permitted by 42 CFR Part 2. A general author	ization for the release of medical or other	
information is NOT sufficient for this purpose. The Federal ru	ales restrict any use of the information to	

criminally investigate or prosecute any alcohol or drug abuse patient.