

The *Consent to Release Information* form must be filled out completely to comply with HIPAA regulations and in order to fulfill the request.

Required fields are:

- **Patient Full Name and Date of Birth**
- **Person or Facility** to whom the information is to be provided
- **Address** where the information needs to be sent
- **Information requested**
 - **Type of information**
 - **Date of services**
- **Reason for request**
- Please check and initial any boxes in the **Specific Authorization for Release of Information** Protected by State or Federal Law that you **do not** want released.
- **Sign and Date** after the “X”
- **Relationship** if not the patient.
 - Minors (under 18 years old) – patient’s legal guardian or parent signs
 - Please call if you have questions as to who can sign for another person’s records.

Optional fields are:

- If you know the record source (hospital, clinic, etc.) otherwise, release is based on the information requested and dates of service provided.
- If the delivery method is not complete, hardcopy/paper is the routine delivery method.
- Include the signing person’s address and a Witness Name for signing.

Upon completion of the form please mail it to:

**Great River Medical Center
Attn: HIM Dept.
1221 South Gear Avenue
West Burlington, IA 52655**

Or fax it to **319-768-1970**

Please call the Health Information Management department at 319-768-1900, with any questions. Thank you and have a nice day.

Sincerely,
H.I.M. Department



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:

