Form 1989

CONSENT TO RELEASE OF INFORMATION

Hosp. #:_____

University of Iowa Hospitals and Clinics (UIHC)

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

Patient's Legal Name _____ **Birth Date** _____

By signing this form, I am allowing UIHC to release medical information (please circle: copies? electronic viewing?) concerning the above named patient to the following:

RECORDS DEPOSITION SERVICE, INC.

Name of Person and/or Institution

PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337

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

Check the information to be disclosed (include dates where indicated): ___Minimum necessary, or specify as follows:

__ Medication list __ Allergy list __ Immunization record ___ Problem List (Pt. Summary list)

__ Most recent history and physical, or specify date_____

__ Most recent discharge summary, or specify 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 and date _____

__ Billing Information, specify_____

[X] Other, specify ENTIRE MEDICAL FILE

The reason for release of information is: ____ Insurance ____ 2nd opinion ____ Rehab/disability

____ Personal file ____ Moving out of area [X] Legal ____ Other medical care ____ Transferring 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, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, IA 52242. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge the risks that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address.

UIHC 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 to be released may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).

Substance Abuse_____ Mental Health _____ HIV-related information _____ Genetic testing _____

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

UIHC use only: *Upon satisfying this release, date & sign; record on the Release of Information Tracking (ROIT) system and scan the form in to Epic.* ***If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, complete the following as appropriate and then forward to the Release of Information Office, Health Information Management (HIM) Department, 2 SRF.***

Info. sent: _____ _____ Recorded on ROIT System: _____ _____

Name/Department Date Operator Name/Department Date