Knoxville Hospital & Clinics
"Committed to You"

Hospital: 1002 South Lincoln St., Knoxville, Iowa 50138
Tel: 641-842-1507
Fax: 641-842-1473

Clinics: 1202 W. Howard St., Knoxville, Iowa 50138
Tel: 641-828-7211
Fax: 641-842-7030

Authorization for Release of Protected Patient Health Information

Patient Name: _____ _____ _____
Date of Birth Social Security Number

1. I hereby authorize Knoxville Hospital & Clinics to: ___ obtain my information from:
___ release my information to:

_____ _____
Telephone Number

Address: _____

2. Information to be Released: **Treatment Dates:** _____

____ History & Physical Examination
____ Consultation by Dr. _____
____ X-Ray Films
____ Operative Report(s)
____ Discharge Summary Short Stay
____ Emergency Room Report
____ Clinic Notes
____ Pathology Report(s)
____ Physician Notes
____ Other-Specify_____
____ Laboratory Data
____ Radiology Report
____ EKG Cardiology Reports
____ Nursing Notes

3. There are no limitations placed on history of illness or diagnostic/therapeutic information, including any treatment of alcohol use/abuse, drug use/abuse, HIV-AIDS, mental health, behavioral or psychiatric treatment.
SIGNER MUST INITIAL THIS CLAUSE: _____ **OR QUALIFY THE ABOVE:** _____

4. The above information is released for the following purpose(s)
___Insurance Purposes ___Employer Requirement ___Continuation of Care ___Personal Reasons ___Legal Purposes ___Other: _____

5. Revocation Process: I understand that I may, by placing my request in writing to the Privacy Officer, revoke this Authorization at any time. However, I understand that a health care organization cannot take back information that has already been released in response to this Authorization. I understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy. This Authorization will expire three months from the date of my signature or as otherwise specified by date, event, or condition as follows: _____

6. Right to Copy/Voluntary Disclosure: I know that I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

7. Health Plan/Insurance Issuers-Conditions: I need not sign this form in order to receive treatment, to have my treatment paid for by my insurer, for enrollment in a health plan or eligibility for its benefits. If I am authorizing my information to be released to an insurance company, I have been advised by my insurer of my rights and the consequences to me should I refuse to sign this Authorization.

8. Photocopy: I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the health care organization may deny the release of protected health information, if it has reason to believe (1) this authorization has been altered or (2) is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which records are being requested.

9. Agreement: I agree to waive all claims against the facility for release of my information pursuant to this request. I understand that I must make an appointment with the Health Information Management Department to review my records. I understand that the hospital typically needs an average of 5 days to prepare copies of the records. If I intend to pick up my copies, the Health Information Management Department will notify when the copies are available.

10. Fees: The Health Information Management Department is permitted to charge me for the copies and any postage associated with shipping the requested copies. Payment for the copies is due at time of receipt.

_____ _____
Patient's Signature (Photo identification may be required) **Date (Must be within 90 days)**

_____ _____
Signature of Other Individual **Relationship of Other to Patient**

Attach Documentation to PR on authority to act on behalf of Patient

REDISCLOSURE: I understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by Federal confidentiality rules. **SIGNER MUST INITIAL THIS CLAUSE:** _____

PROHIBITION OF REDISCLOSURE: Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical information is not sufficient for this purpose.

Information has been released per authorization by _____ on date: _____