Authorization to Release Protected Health Information

KNOXVILLE Hospital & Clinics | An Affiliate of MERCYONE

This form collects information that is part of the medical record. **Route to Scanning.**

Name *(First, Middle, Last)*	Birth Date *(MM, DD, YYYY)*
Additional Name(s) Used *(e.g. maiden name, prior name)*	

Instructions: If **any** section is incomplete, this form may be invalid.

Release Information from:

☐ Knoxville Hospital & Clinics, 1202 West Howard, Knoxville, IA 50138
Phone (641) 842-7012 Fax (641) 842-7030

☐ Other *(Specify entity & address below, including phone/fax if known)*

Release Information to:

☐ Knoxville Hospital & Clinics, 1202 West Howard, Knoxville, IA 50138
Attn: Health Information Management Department

☐ Other *(Specify entity & address below, include phone/fax, if known)*

Purpose of Release

☐ Treatment/Continued care ☐ Personal ☐ Legal purposes ☐ Transfer
☐ Application for insurance ☐ Disability determination ☐ Payment of insurance claim
☐ Other

Information to Be Released

(Required - check all that apply)

☐ Clinic notes ☐ Hospital discharge summary ☐ Laboratory Reports ☐ Radiology Reports
☐ History and physical ☐ EKG's ☐ Operative Reports ☐ Radiology Images
☐ Hospital Notes ☐ Immunization records ☐ Pathology Reports ☐ Billing Information
☐ Other (specify information to be released in the space below)

Method of release ☐ Paper ☐ Fax (healthcare provider only)

Service dates From To	Information needed by (optional)

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here:

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ☐ Parent ☐ Legal Guardian

Signature *(Required)*		**Date Signed** *(Required)*	
Printed Name of Person Signing *(If Not Patient)*			
Mailing Address of Patient - Street			
City	State	ZIP Code	Phone