CONSENT TO OBTAIN INFORMATION

University of Iowa Student Health

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

Patient Name _____ Birth Date _____ Student ID # _____

I, the undersigned, hereby authorize: to release medical information concerning the above-named patient to:

_____ Name of Person and/or Institution _____ Complete Mailing Address/Street/P.O. Box _____ City, State, Zip Code	University of Iowa Student Health 4189 Westlawn Iowa City IA 52242-1100 Fax: 319-335-7247

☐ **Information checked below is for <u>phone release</u> only. Phone number:** _____

Check the information to be disclosed (include dates where indicated): ☐Minimum necessary or specify

☐ Entire Record
☐ Medication list ☐ Allergy list ☐ Immunization record
☐ Most recent history and physical or specify date(s) _____
☐ Clinical notes related to visit(s), specify visits or date(s) _____
☐ Test results (i.e. lab, X-ray, EKG, etc.), specify type and date(s) _____
☐ Billing information, specify _____
☐ Other, specify _____

As per my request, the reason for release of information is: ☐ medical care ☐ legal ☐ insurance
☐ Other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Director of Medical Records, University of Iowa Student Health, 4189 Westlawn, Iowa City, IA 52242-1100. I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure, and 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 Medical Records at the above address. I have been offered a copy of this authorization.

I understand that University of Iowa Student Health may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in a denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (***<u>initial</u>*** any category ***<u>not</u>*** to be released).

Substance Abuse* _____ Mental Health _____ HIV-related information _____ Genetic tests/info** _____

*Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). **Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement will expire two years from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____

_____
Signature of Patient or Legal Guardian Date

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

_____
Relationship, if Not the patient

Student Health Use Only:

Form Sent: _____ Scan into Epic Original: To be sent Copy: Patient
Name Date