Form 1989 Hospital #: _____

ADMIN – CONSENT TO RELEASE OF INFORMATION AND RIGHT OF ACCESS REQUEST

University of Iowa Health Care

University of Iowa Student Health, 4189 Westlawn, Iowa City, IA 52242 Telephone: 319-335-8370; Fax: 319-335-7247
Email: student-health@uiowa.edu

Patient legal name: _____ **Birth date:** _____

Complete mailing address: _____

List any previous names (maiden, married, legal changes): _____

Send Student Health (SH) ☐ Myself at the address above unless noted below

info to: Name/facility: _____

Complete mailing address: _____

Format of information to be released:

☐ Electronic: ☐CD ☐USB drive ☐MyChart ☐ Verbal ☐ To file only ☐ Paper

☐ Fax: _____ ☐ Email: _____
(Email is not a secure means of communication)

Information to be released (will be from the previous two years unless specified below)**:**

☐ Summary of record	☐ Immunization record	☐ Pathology slides
☐ Billing information	☐ Laboratory results	☐ Psychotherapy notes
☐ Discharge notes	☐ Office visit notes	☐ Radiology images
☐ Emergency notes	☐ Operative/Procedure reports	☐ Radiology reports
☐ History and physical	☐ Pathology reports	☐ Test results (EKG, PFT, EMG, etc.)

☐ Other: _____

Date(s): _____ to _____ **and/or Department/Provider:** _____

Reason for release:

☐ Rehab/disability ☐ Insurance ☐ Legal ☐ Personal ☐ Medical ☐ Other: _____

This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Director of Health Information Management at the above address. 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 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. I have been offered a copy of this authorization. I understand there may be a charge for this information.

Student Health (SH) 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 may be released electronically, and may include information in the following categories unless I specifically deny the release **(*check* any category *not* 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 allows release of past and future SH information and will expire 2 years from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian. SH will respond to this request within 30 days of receipt. If additional time is required, you will be notified of the extension.

Signature: _____ **Date:** _____
(Patient or person legally authorized to consent for patient)

_____ _____
(Printed name of legally authorized person signing) (Relationship of legally authorized person)

_____
(Witness signature, only required when patient or person legally authorized is physically unable to sign)

Internal use only: _____ Initial if form has been processed and scanned into Epic under the *HIM ROI Authorization* document type.

Revised: 8-2021

CLICK here to SUBMIT to Student Health