Veterans Memorial Hospital - 40 First St. SE, Waukon, Iowa 52172
Phone 563-568-3411 Fax: 563-568-6139

Authorization for Disclosure of Health Information

Name of Patient/Previous Names

Birth Date/Medical Record Number

Street Address

City, State, Zip

AUTHORIZES DISCLOSURE BY:

❑ Veterans Memorial Hospital

Or By:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

DISCLOSURE OF HEALTH INFORMATION TO:

❑ Veterans Memorial Hospital

Or To:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip Code

INFORMATION TO BE DISCLOSED: *Identify below the specific information to be disclosed along with relevant dates of service; this information may include history & physicals, discharge summaries, clinical notes, diagnostic studies, etc.*

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure*

❑ Medical ❑ Insurance ❑ Legal ❑ Personal ❑ Other_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy the Health Information to Be Used or Disclosed - I understand that I have right to inspect or receive a copy the health information I have authorized to be used or disclosed by this authorization form. Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign thi form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to Withdraw This Authorization - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Veterans Memorial Hospital. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. Veterans Memorial Hospital will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

EXPIRATION DATE: This authorization is good until the following date(s)_____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP:_____DATE:_____

*If signed by other than patient, state relationship:*_____

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of health information relating to the testing, diagnosis, and treatment for:

❑ HIV/AIDS Virus ❑ Mental/Behavorial Health Conditions ❑ Drug/Alcohol Abuse/Treatment

SIGNATURE PATIENT/LEGAL REPRESENTATIVE:_____DATE:_____

*If signed by other than patient, state relationship:*_____

FOR ORGANIZATION'S USE		
Date Received:	Date Disclosed:	❑ Mailed ❑ Faxed ❑ Picked Up By: