Authorization to Disclose Health Care Information

Luther College Health Service
700 College Drive Decorah, IA 52101
Phone 563.387.1045 Fax 563.387.1053

Patient Information:

Patient Name: ______________________________ Student I.D.# ______________

Former Name (if any) ______________________________ Birth Date ______________

Address ____

Phone # ______________ Cell Phone ______________ E-mail ______________

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH CARE INFORMATION AS INDICATED:

Release Information From:

____

____

____

Send My Information To:

____

____

____

Method for sending information (circle one) Mail Hold for Pick Up Fax Hand Carry Date Needed: ________

Medical Information Requested to be sent:

- ❑ Complete Records
- ❑ Labs
- ❑ X-ray Reports
- ❑ Gyn/Pap/Depo
- ❑ Immunization
- ❑ Other

____

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Reason for Release:

- ❑ To update my regular provider
- ❑ I have been referred to another doctor
- ❑ I want/need a second opinion
- ❑ I am changing doctors
- ❑ I am moving
- ❑ Talk with Parent/Guardian
- ❑ Other ______________________

Specific Authorization for Release of Information Protected by State or Federal Law

You Must Circle Yes or No

I Specifically authorize the release of data and information relating to:

Yes	No	1. Substance Abuse (alcohol/drug abuse)
Yes	No	2. Mental Health (ADD, depression, anxiety, testing)
Yes	No	3. HIV related information (AIDS related testing)

Federal and/or State Law specifically require that any disclosure or re disclosure of substance abuse, alcohol or drug, mental health, or AIDS related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See Also Chapter 228 of the Iowa Code (Mental Health) and Section 141A.9 of the Iowa Code (AIDS) and other applicable confidentiality laws.

I UNDERSTAND THAT:

- This authorization will automatically expire one year from the date of my signature or on ______________.
- This authorization may be revoked at any time by notifying Luther College Health Service in writing except to the extent that action has been taken in reliance on it.
- I can request an accounting of disclosed information by writing to the Health Service.
- My refusal to sign, or revocation of, this authorization will not affect my ability to obtain health care services from Luther College Health Service.
- The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy rules.

______________________________ ______________
Signature of patient or legal guardian (patients over 18 must sign release) Date

______________________________ ______________
Relationship and authority, if not the Patient Witness