MASON CITY CLINIC
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

Name: _____
LAST FIRST MI

Birth Date: ____/____/_____ Social Security #: _____

Address: _____
STREET CITY STATE/ZIP

Telephone Number: _____ _____
HOME OTHER

INFORMATION BEING SENT TO/FROM (CHECK ONLY ONE)

☐ This information is to be released **FROM** Mason City Clinic to the facility or individual specified below:

_____
NAME/FACILITY/INDIVIDUAL

_____
ADDRESS

_____
CITY STATE/ZIP

_____
PHONE

_____
FAX

☐ This information is to be released **TO** Mason City Clinic:

_____
NAME/FACILITY/INDIVIDUAL

_____
ADDRESS

_____
CITY STATE/ZIP

_____
PHONE

_____
FAX

TYPE OF INFORMATION BEING REQUESTED

For date(s) of service: _____ Physician(s) _____

- ☐ Office Visits
- ☐ X-Ray Reports ☐ Images
- ☐ Lab Reports
- ☐ Surgery Reports
- ☐ Billing/Financial Information As Needed
- ☐ Other_____

*****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY STATE OR FEDERAL LAW*** See reverse for details.**

Initial any category authorized TO BE released:

_____ Acquired immunological syndrome (AIDS) or human immunodeficiency virus (HIV)
_____ Alcohol and drug abuse treatment
_____ Behavioral or mental health services (includes psychological testing)

PURPOSE FOR DISCLOSURE

- ☐ Transferring Care
- ☐ Second Opinion
- ☐ Personal Use
- ☐ Moving
- ☐ Insurance Claim
- ☐ Legal Review
- ☐ Other _____

TIME LIMIT

I understand that I may cancel this authorization at any time by sending a written notice to Mason City Clinic's Records Release department and that my cancellation will take effect when the written notice is received and it will not apply to information that has already been released in response to this authorization. This authorization will automatically expire 1 year from the date of signature except as specified. (Specify expiration date, event, or condition):

_____

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected by federal privacy regulations unless otherwise prohibited from redisclosure under other federal and/or state laws or regulations.

SIGNATURE AND DATE (A copy of this signed form will be provided to the patient.)

_____ _____
SIGNATURE (PATIENT OR LEGAL REPRESENTATIVE) DATE

_____
RELATIONSHIP, IF NOT PATIENT

Signature must be verified with a Photo ID. A copy of your Photo ID with signature must accompany this form.

☐ Photo ID Checked by _____ Information processed and sent (date & initials)_____

State and/or Federal law specifically requires that with any disclosure or redisclosure of substance abuse (alcohol or drug), mental health, or AIDS/HIV related information, the following written statement must accompany information.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 cfr part 2). The 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 law. A general authorization for the release of medical or other information is not sufficient for this purpose.

I understand I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services or repayment or my eligibility for benefits. I also understand that if I revoke, the revocation will take effect on the day it is processed by Mason City Clinic.

I understand as a patient I have the right to access my records. Copies of the records may be obtained with reasonable notice. Mason City Clinic reserves the right to charge a reasonable fee for these services. I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.