Van Buren County Hospital
Simply Remarkable

An Affiliate of MERCYONE

Garen G. Carpenter, CEO
304 Franklin Street • Keosauqua, IA 52565
Phone 319.293.3171 • www.vbch.org

MRN:_____

Authorization for Release of Health Information

Patient Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

I hereby authorize _____ **to use and/or disclose my health information as follows**

Disclose to: _____
Recipient Name **Phone**

_____ _____
Address: **Fax:**

Purpose(s) of Disclosure: _____

- ☐ Check this box if disclosure is at the request of the individual
- ☐ If the purpose for the disclosure is marketing, check this box only if VBCH will receive direct or indirect remuneration from a third party.

INFORMATION TO BE DISCLOSED: (*check all that apply*)

- ☐ History & Physical Examination
- ☐ Progress notes
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Consultation Report
- ☐ Other:_____
- ☐ Emergency Room Record
- ☐ Discharge Summary
- ☐ After Care Plan
- ☐ Financial Record
- ☐ **Complete Record**

***** SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW*****
PLEASE CHECK EITHER YES OR NO IN EACH APPLICABLE LINE TO RELEASE THE SPECIFIC INFORMATION:

Substance use/abuse ☐ Yes ☐ No
Mental Health ☐ Yes ☐ No
HIV/STD related information (including test results) ☐ Yes ☐ No

DATES OF SERVICE OR TIME PERIOD TO BE DISCLOSED: _____
(State time period or "ALL")

I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management.

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at VBCH.
2. Medical Information to be disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal law.
3. This authorization is effective for **12 months** after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to **VBCH HIM Department.** My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.

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

_____ _____
Signature of patient or patient representative **DATE**

_____
Relationship to the patient if signed by personal representative