Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

509 North Madison
Bloomfield IA 52537
Ph# 641-664-2145
Fax# 641-664-2176

RECEIVED	COMPLETED	LOGGED

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or it has expired as described below. A copy of this signed form will be provided to the patient.

I hereby authorize Davis County Hospital & Clinics to disclose the following information from the health records of

_____
Patient Name and Date of Birth

_____ Telephone#: _____
Address (City, State, Zip)

This information is to be disclosed to:

_____
Name of Institution/ Physician/Spouse/Guardian/legal Representative

_____
Address (City, State, Zip)

Covering the periods of healthcare (Date(s) of Service):

From (date)_____ to (date)_____

For the purpose of: _____
(not required if the disclosure is requested by the patient)

Prefer to acquire records by: Paper ☐ Disc ☐ Fax ☐ Fax #:_____
Encrypted email ☐ Unencrypted email ☐ Email Address: _____
If you chose "unencrypted email" please be aware there is some level of risk that your medical information could be read or otherwise accessed by a third party while in transit. By selecting unencrypted email and signing below, you have accepted this risk and still want your medical information sent by unencrypted email.

Information to be released:

Complete health record	_____	History and Physical	_____	Other:_____
Discharge Summary	_____	Operative Report	_____	_____
X-ray Films	_____	Lab, X-ray Report	_____	_____

I understand that this may include information in the following categories unless I specifically deny the release (Initial any category <u>not</u> to be released):

_____HIV/AIDS-related Information _____ Behavioral health service/psychiatric _____Tx-alcohol and/or drug abuse

Affirmation of Release

I give Davis County Hospital permission to release only the information I have selected on this form to the individual or agency I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility or benefits. The revocation will take effect on the day it is received in writing. As a patient, I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

_____ _____
Signature of Patient/Guardian/Legal Representative Date Signed

_____
Relationship if other than Patient

Expiration Date:_____
One year from date signed