Provider_____

RIVERHILLS COMMUNITY HEALTH CENTER
Diversified Services · Exceptional Healthcare

201 S Market St PO Box 458
Ottumwa IA, 52501
Phone: 641-684-6896 FAX: 641-684-3080 or 641-682-0484 or 641-682-9798
Email: medrecords@riverhillshealth.org

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Please complete all boxes, sign and date.
There may be a fee for copies of records.

1) Name of Patient/Client

_____
Last First MI

_____
Address

_____
City/State/ZIP

_____ _____
Phone Date of Birth

2) I authorize River Hills Community Health Center To:
PLEASE CIRCLE ALL THAT APPLY
RELEASE TO: RECEIVE FROM: EXCHANGE WITH:

_____
Name of person and/or facility

_____
Address

_____
City/State/ZIP

_____
Phone

_____
Fax

3) Description of health information that may be disclosed (check applicable box(es) :

- ☐Immunization Record
- ☐Lab Results
- ☐History and Physical
- ☐Communication
- ☐Dental
- ☐Clinic notes
- ☐X-Ray/Radiology
- ☐Medication
- ☐Behavioral Health notes
- ☐Other:_____

4) Specific Authorization for release of information protected by state or federal law. Please initial or put an X by each applicable item

_____Substance/Alcohol Abuse
_____Mental Health
_____HIV/AIDS Information
_____Genetic Testing

_____ _____
Signature of Patient/Client/Personal Representative Date

_____
Relationship, if not the patient/client

5) Reason(s) for releasing this information:

- ☐Transferring Care
- ☐Personal
- ☐Other:_____

6) Expiration Date:
This authorization will expire one-year from the date of signature, or as indicated(but not to extend past 12 months) _____. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by given written notice.

7) Time frame to release: (If not completed, last 2 years will be sent.)

This authorization to release information is voluntary. I know I do not have to complete this form in order to receive treatment. By signing this form I am allowing River Hills CHC to release my confidential health information to the person or facility listed. I acknowledge that (1) recipients of this information may possibly re-release the information without proper authorization and (2) once information is disclosed it may no longer be protected by federal privacy regulations. I know I have the right to inspect the information to be disclosed, unless restricted by law, upon the proper notification to and under conditions established by River Hills CHC. I understand my healthcare and payment for my healthcare will not be affected by this authorization. By signing this form, I authorize the disclosure described above. I understand the information may be released orally or via fax, mail or electronically.

_____ _____
Signature of Patient/Client or Patient's/Client's Personal Representative Date

If signed by patients' representative, please PRINT representative's name and describe his/her authority.
Representatives Authority: ☐ Parent ☐ Guardian ☐ Power of Attorney
Name: _____
☐ Other _____

Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of 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.

Staff Initials:_____