LINN COUNTY PUBLIC HEALTH
1020 6TH ST. SE
CEDAR RAPIDS, IOWA 52401
PH: 319-892-6000 | FAX: 319-892-6099

Pramod Dwivedi, DrPH, MS, MSW, MA | Health Director

LinnCountyIowa.gov

Release of Information Form

Patient Information	Name: ________________ (Last) ________________ (First) ______ (Middle Initial) Birth Date ______-______-______ Maiden/Other Name: ________________ Daytime telephone number(s): ________________
Provider releasing PHI	Healthcare Provider: ________________
PHI Requested to be released	☐ Office visit notes ☐ Emergency room notes ☐ Immunization record ☐ Radiology reports of ____________ ☐ Pregnancy record ☐ Lab results ☐ All records ☐ Other ____________ Specify dates of service (if applicable) ________________
Required Authorization (Initial each)	**Specific Authorization for Release of Information, which is Further Protected under State and/or Federal Law.** Y / N _____ Acquired Immunodeficiency Syndrome (AIDS) or Human immunodeficiency Virus (HIV) Y / N _____ Alcohol or drug abuse treatment Y / N _____ Behavioral or Mental Health Services
Party(s) to receive patient's PHI as indicated below	Name: ________________ Organization: ________________ ☐ Mail to address: ________________ ☐ By Phone: (___) ____________ ☐ By Fax: (___) ____________ Name: ________________ Organization: ________________ ☐ Mail to address: ________________ ☐ By Phone: (___) ____________ ☐ By Fax: (____) ____________
Purpose for disclosure	☐ New healthcare provider ☐ Insurance ☐ Personal Use ☐ Continuation of care ☐ Legal purpose ☐ Other (please specify) ________________
Authorization Expiration	I understand that I may cancel (revoke) this authorization at any time by sending a written notice to Linn County Public Health and that my cancellation will take effect when the written notice is received. A photocopy of facsimile of this release shall have the same effect as an original. I understand it will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one (1) year from date of signature except as specified below: Expiration Date, Event or Condition limitation: ________________
Signature and date	**PROHIBITION FOR RE-DISCLOSURE**: This information has been disclosed to you from records whose confidentiality is protected by Federal and/or State Law. The Authorization for Release of Medical Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, and State Law for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such laws and/or regulations. A general authorization for the release of medical information is NOT sufficient for these purposes. Civil and Criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/SIDS information. ________________ Patient/Guardian signature: ________________ Date If guardian, state relationship or basis for authority to sign. ________________

☐ Copy to patient or responsible party ☐ Copy mailed or faxed ☐ Verified ID, provided releas

G: Health/Nursing/Consents and Release of Info/2019ROI ; Original 2019 updated 2021