Hospital # ____________

CONSENT TO RELEASE OF INFORMATION
University of Iowa Hospitals and Clinics (UIHC)

Please PRINT (except signatures) and provide complete information in each section.

Patient Name ______________________ Birth Date ____________ Soc. Sec. # ____________

I understand that by signing this form I am allowing UIHC to release medical information concerning the patient named above to:

BLACK HAWK AREA EDUCATION
Name of Person or Institution

4670 11TH STREET — EAST MOLINE, IL 61244-4432
Complete Mailing Address/Street/P.O. Box — City, State, Zip Code

Check the information to be disclosed (include dates where indicated): ☐Minimum necessary or specify:
- ☐Medication list ☐Allergy list ☐Immunization record ☐Problem List (Patient Summary List)
- ☐Most recent history and physical or specific date ____________
- ☐Most recent discharge summary or specific date ____________
- ☐Laboratory results, specify type or date ____________
- ☐X-ray and imaging reports, specify type or date ____________
- ☐Consultation reports from (doctors' names or clinic) ____________
- ☐Test results (i.e., EKG, PFT, etc.), specify type and date ____________
- ☐Billing Information, specify ____________
- ☐Other, specify ____________

As per my request, reason for release of information is: ☐Medical care ☐Legal ☐Insurance ☐Other (specify) ________

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Director of Health Information Management, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, IA 52242. I understand that any release that was made prior to my cancellation in compliance with this authorization, shall not consitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address.

I understand that UIHC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

Substance Abuse ____________ Mental Health ____________ HIV related information ____________

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) ____________.

Signature of Patient or Legal Guardian — Date

Complete Mailing Address/Street/P.O. Box — City/State/Zip Code

Relationship, if Not the Patient — Witness Signature

UIHC use only: Upon satisfying release, date & sign, record on the Release of Information Tracking (ROIT) system, and file the original of this form in the back of the medical record. If unable to enter this information release on the ROIT system, forward the consent to the Release of Information Office, HIM, 2 SRF.

Info. sent: ____________ Name/Department — Date
Recorded on ROIT System: ____________ Operator Name/Department — Date