Ringgold County Hospital
Mount Ayr Medical Clinic
504 North Cleveland Street
Mount Ayr, IA 50854

Phone: (641) 464-3226
Ringgold County Hospital Fax: (641) 464-4436
Mount Ayr Medical Clinic Fax: (641) 464-4476

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
SSN: _____ Phone: (H): _____ (W): _____
Address: _____
Street City State Zip

I, the undersigned, do authorize and request Mount Ayr Medical Clinic and/or Ringgold County Hospital to release information to OR obtain information from:

Provider or facility: _____
Phone: _____ Fax: _____
Address: _____
Street City State Zip

PURPOSE FOR THIS REQUEST: (*please check)*
☐Healthcare ☐Insurance Coverage ☐Personal ☐Transfer of Care ☐Other _____

TYPE OF RECORDS REQUESTED:
☐All medical records related to a specific injury or illness _____
☐Treatment summary (includes H &P**,** lab tests, x-ray reports, operative reports, pathology)
☐Specific information (*Select one or more, as applicable)*
☐Procedure report ☐History and physical ☐Physical therapy
☐Medical Imaging reports ☐Medical Imaging CD ☐Laboratory results
☐ Other _____
☐Copy of entire medical record, as by law

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: *(check appropriate box(es), initial and sign/date)*
_____☐ Mental Health Treatment _____☐Drug or Alcohol Abuse Treatment _____☐HIV/AIDS test results

_____
Signature of patient or authorized representative Date

AUTHORIZATION VALID FOR: (*check one)*
☐ This request only. ☐ One year from the date of this authorization.

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 giving written notice to the Director of Health Information at Ringgold County Hospital or Mount Ayr Medical Clinic.
I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Ringgold County Hospital or Mount Ayr Medical Clinic.
I understand that my health care and payment for my health care will not be affected if I do not sign this form.
I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, I understand this authorization is voluntary.

_____
Signature of Patient or Patient's Authorized Representative

_____
Date

_____
Relationship of Authorized Representative

PROHIBITION OF REDISCLOSURE
This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, and HIV/AIDS test results, federal requirements (42-C.R.F. Part2) and state requirements (Iowa Code ch. 228 & ch. 141) prohibit further disclosure without the specific written consent of the patient or as otherwise permitted by such law or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information related information or HIV/AIDS test results.

Signature of Witness: _____Date: _____

Distribution: Original - medical record. Copy - requestor, as required