Linn County Public Health
501 13th Street NW
Cedar Rapids, IA 52405
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LinnCounty.org

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 release, staff