AUTHORIZATION TO RELEASE INFORMATION

Name of Patient: ____________________________
Date of Birth: ____________________________

AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE

I authorize ____
whose address is ____
to disclose and deliver to ____ whose address is
____ the following information:

Information related to the care and treatment of ____________________________, including but not limited to, doctor and nurse notes, diagnostic and laboratory orders and results, and prescription and medication orders.

NOTE: If the information includes mental health treatment, substance abuse treatment or HIV-related information it will not be released unless the undersigned patient agrees to the release on the reverse side of this form.

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against ____.
and/or arising out of incident(s) of on or about the ______ day of ______________________, 20____.

This release expires on ________________________(not to exceed one year); or, if no date is specified, on the termination of the litigation or other proceedings for which this authorization was provided.

This authorization is given pursuant to the provisions of section 622.10(3)(a)(1), (2)b and c, Iowa Code (2001).

I understand I have a right to inspect the disclosed information at any time and I hereby invoke that right and require, as a condition precedent to the use of the Authorization, that the attorney ________________________or any attorney in the law firm of ____, receiving any information through the use of this Authorization provide my attorney of record notice each time this authorization is used and, in addition, promptly provide copies of all information received through use of this authorization in accordance with Rule 1.500(c)(1) of the Iowa Rules of Civil Procedure.

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from whom disclosure is sought in writing.

I understand that if the person or entity that receives the information requested is not covered by federal privacy regulations or is not an individual or entity who has signed an agreement with such person or entity, the information described above may be re-disclosed and will no longer be protected by the regulations.

Iowa and/or Federal law provides that I have a right to prohibit REDISCLOSURE of confidential medical information and further disclosure may not be had without my express written authorization, as indicated below.

I further understand that the Recipient, WITHOUT FURTHER AUTHORIZATION, may re-disclose said information to:

(A) Parties and their legal counsel, insurers, experts, potential experts, anyone whom claim is or has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any of said persons only; OR INSTEAD
(B) [__] [CHECK ONLY IF APPLICABLE] ONLY to the following:____

I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

Dated: ______________________________

____

NOTICE TO HEALTH CARE PROVIDERS REGARDING AUTHORIZATION FOR CONSULTATION

A). HEALTH CARE PROVIDERS LISTED ABOVE SHALL NOT COMMUNICATE WITH DEFENSE COUNSEL OR ANY INSURANCE AGENT, INSURANCE ADJUSTER, INVESTIGATOR OR OTHER PERSON(S) SEEKING INFORMATION ABOUT ME PURSUANT TO THIS PATIENT'S WAIVER UNLESS COUNSEL FOR THE PATIENT IS PRESENT.

B). The undersigned specifically asserts the physician -patient privilege except to the extent that it is abrogated by Section 622.10(3)of the Iowa Code.

C). This release does authorize you to consult with the attorney for the adverse party prior to providing testimony regarding your patient's medical history and the condition alleged and opinions regarding health etiology and prognosis. I have the right to have my attorney present at any such meeting. This release does NOT authorize discussing of my care or health matters or meeting with attorneys for the adverse party unless my attorney is present.

D). Counsel for the above-referenced patient is ____

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E). The undersigned, your patient, SPECIFICALLY PROHIBITS ANY HEALTH CARE PROVIDERS LISTED ABOVE FROM COMMUNICATING WITH DEFENSE COUNSEL UNLESS PATIENT'S COUNSEL IS PRESENT.

Dated: ______________________________

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SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable boxes:]

☐ Substance Abuse (Drug or Alcohol) Information from:

____

____

(Name of Agencies, facilities, or individuals)

☐ Mental Health Information from:

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____

(Name of Agencies, facilities, or individuals)

☐ AIDS - related Information, Diagnosis, and test results from:

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(Name of Agencies, facilities, or individuals)

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and re-disclosure of this confidential information to all of the persons referred to in the REDISCLOSURE Section I.

In order for the above information to be released, you must sign here AND at the end of Section I.

Dated: ______________________

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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 written statement:

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 this 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 patients.

SEE ALSO Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.