Instructions for completion of Authorization:
Please complete the following steps
Section 1: Patient Identification - complete all areas
Section 2: Provider: Check SMCH (hospital records) or McCrary-Rost Clinics (clinic records) or if the purpose of this release is to obtain records from an outside entity, please list who you are requesting records from.
Section 3: Recipient - Complete all blanks
Section 4: Purpose: Please specify reason for records release
Section 5: Information: What should specifically be released.
Section 6: Specific authorization for release of protected Health information:
Initial by areas to be released. Depending on what is checked we may be unable to fulfill this authorization. Initialing all areas will insure your complete record is released.

Sign and date
*If patient is under the age of 18, release must be signed by parent or legal guardian.

Options to return release:
Fax: 712-464-7412, Attention: Health Information Mgmt.
Mail:
Stewart Memorial Comm Hospital
Attn: Health Information Mgmt
1301 W. Main
Lake City, IA 51449

If you have any questions regarding completing this authorization, please call 712-464-3171, ext. 6465.

Note: Records are mailed with 7 to 10 days of receipt of release
Records are faxed only in a medical emergency
If records are needed for an upcoming appointment, please note the date of the appointment on the release.

SMCH
1301 W. Main
Lake City, IA 51449
712-464-3171
Fax: 712-464-7412

McCrary-Rost Clinic
1800 W. Main St.
Gowrie, IA 50543
515-352-3891

McCrary-Rost Clinic
1351 W. Main
Lake City, IA 51449
712-464-7907

McCrary-Rost Clinic
1160 3rd St.
Lake View, IA 51450
712-665-8555

McCrary-Rost Clinic
505 E. Lake St.
Rockwell City, IA 50579
712-297-8989

Authorization for Release of Medical Information

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the entity 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.

This authorization is effective for one year from the date on which it was signed. 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 Stewart Memorial Community Hospital. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the organization.

PATIENT IDENTIFICATION	Name (last, first, middle initial): _____ Date of Birth: _____ Last 4 digits of Soc. Sec.#: _____ Any previous names under which records may be kept: _____ Telephone number where we can reach you if we have questions: _____
PROVIDER (Who is to disclose the information?)	☐ SMCH ☐ McCrary-Rost Clinics ☐ Other entity (please specify): _____ Street address: _____ City, State and Zip: _____
RECIPIENT (Who is to receive the information?)	Name: _____ Street address: _____ City, State and Zip: _____ Telephone number: _____ Fax number (if applicable): _____
PURPOSE OF RELEASE (Check all that apply)	☐ At request of the patient (or legal representative) ☐ Discussion/coordination of care with family members involved with patient's care ☐ Transferring medical care to another health care provider ☐ For claims processing purposes (e.g. third-party liability claims) ☐ Other (please specify): _____
Information (What information should be released?) (Check all that apply)	☐ Records dating from: _____ to: _____ ☐ History & Physical Examination ☐ Emergency Room Record ☐ Consultation Report ☐ Progress Notes ☐ Discharge Report ☐ Complete Record ☐ Lab Reports ☐ Clinic Notes ☐ X-ray Reports ☐ Financial Record ☐ Other: _____

I understand my healthcare and payment for my healthcare will not be affected by this authorization.

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

I understand that the records released may contain information related to the following and I authorize release of this protected information: *(Please Initial)*

_____ Mental health
_____ Substance abuse treatment (Alcohol/Drugs)
_____ HIV-related information (including AIDS and related testing)
_____ Genetic testing information

Signature of patient or legal representative: _____ Date: _____

Relationship to patient, if signed by legal 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 and HIV/AIDS records, federal requirements (42 C.F.R., Part 2) and state requirements (Iowa Codes Chapters 228 and 141.23) prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by law or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS-related information.

Completed by: _____ Date: _____