Cass Health

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification	Name: _____ Date of Birth: _____ Address: _____ Phone: _____	
Obtain From	Name	
	Address	
	City/State/Zip	
	Phone	
	Fax	
Disclose To	Name	
	Address	
	City/State/Zip	
	Phone	
	Fax	
Type of Information Requested	Dates of service: _____ ❑ History/physical exams ❑ Radiology reports ❑ Discharge summaries ❑ Progress notes/clinical notes ❑ Consultation reports ❑ Treatment plan/diagnosis ❑ Lab reports ❑ Emergency room records ❑ Complete records ❑ Pathology reports ❑ Other_____	
	SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY LAW Initial any category NOT to be released: _____ Mental Health Information _____ Substance abuse (drug or alcohol) _____ HIV/AIDS-related information _____ Genetics tests/info	
Purpose For Disclosure	❑ Patient care ❑ Insurance claim ❑ Personal use (*Fees apply*) ❑ Legal review (*Fees apply*) ❑ Other (*Specify*): _____	
Time Limit	This authorization is effective for _____ months after the date it was signed (12 months max). ***I understand or acknowledge that:*** My refusal to sign this authorization will not affect my ability to obtain treatment at Cass Health. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by state or federal law. I understand the content and nature of the material I am releasing. I understand that I may read or have a copy of this document. A photocopy of this signed authorization shall have the same force and effect as the original. This authorization is valid for the duration of one (1) year. I understand that I may revoke this authorization by providing a signed and dated written request to Cass Health Medical Records. I understand that previously disclosed information would not be subject to my revocation. I certify under penalty of perjury and pursuant to the laws of the state of Iowa that the preceding is true and correct.	
Sign & Date	_____ _____ *Signature of patient or patient's personal representative* *Date*	
	_____ _____ *Authority of personal representative* *Witness*	
	Legal documentation is required for proof of legal guardianship or Power of Attorney.	

Request completed by_____ Date_____ Number of pages_____ 7/2021