1801 Hickman Road
Des Moines, IA 50314-1597

Phone: 515-282-2482 FAX: 515-282-2231

Authorization to Use or Disclose Health Information

Patient's Legal Name: ______________________ Date of Birth: ____/____/______ MR#: ____________

1. I authorize Broadlawns Medical Center to:
   ☐ obtain records from ☐ release records to ☐ communicate with

2. ____
   Name of third party and/or Institution

   ____
   Complete Mailing Address (Street/P.O. Box, City, State, Zip Code, phone/fax numbers)

2. Description of health information that may be used or disclosed (check all that apply):
   ☐ History and physical ☐ Discharge summary ☐ X-ray and imaging reports ☐ Lab results
   ☐ Consultation reports ☐ Test results (e.g. EKG, PFT, etc.) ____________ ☐ Other, specify: ____________

3. Concerning the care of the above patient from (select one):
   ☐ Any and all dates; or ☐ Dates ____/____/________ to ____/____/________

4. **Specific Authorization for Release.** The following information requires special consent by law. Even if you indicate **entire medical record** in number 2 above, you must specifically request the following information in order for it to be released (check as appropriate):

   ☐ Mental Health Evaluation/Treatment ☐ Alcohol/Substance Abuse ☐ HIV/AIDS

   ______________________ ________ ________
   Signature of Patient or Surrogate Decision Maker Date Time

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 patient.

5. Reason(s) for releasing information:
   ☐ Continuation of care ☐ Patient's request ☐ Legal ☐ Other, explain: ______________________

6. This authorization will expire one year from date of signature unless otherwise specified
   ☐ ___/___/_____ (specify date)

I understand that I may revoke this authorization in writing at any time by sending a written request to Broadlawns Medical Center at 1801 Hickman Rd., Des Moines, Iowa 50314, Attention Medical Records, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that I may inspect and/or copy the information disclosed. I understand that information disclosed pursuant to this authorization potentially could be subject to re-disclosure by the recipient, and if re-disclosed the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this authorization form. I also acknowledge receipt of a copy of this Authorization.

______________________________ ____________ ____________
Signature of Patient or Surrogate Decision Maker Date Time

If signed by Surrogate Decision Maker, please print name and describe the representative's authority to act for the patient:

______________________ ______________________
PRINT Surrogate Decision Maker's Name Surrogate Authority (i.e. Parent/Guardian/Power of Attorney/Authorized Representative)

Medical Information Management
Authorization to Use or Disclose Health Information

S/MR-0430
64510 4/03; 7/09; 2/10; 5/11; (12/12; 6/13; 7/15; 11/16, 08/19)[rrh]

This release is considered invalid if not completed accurately including date/time