Broadlawns Medical Center
1801 Hickman Road
Des Moines, IA 50314-1597
Phone: 515-282-2482
Fax: 515-282-2231

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Instructions to Patient Please complete ALL sections. Failure to do so could prevent or delay processing.

PATIENT INFORMATION
Enter the patient's information in this section.

Patient Name _____

Former Name/Previous Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ DOB _____ MR# _____

RELEASING ENTITY
Release records from all checked BMC entities

☐ Broadlawns Medical Center – hospital and clinics

☐ New Connections, MAT, Addiction Treatment

☐ Residential homes

☐ Other:
Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

RECEIVING ENTITY:
Enter the information of the entity you want to **receive** your medical records.

Receiving Entity Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

RECORDS TO BE RELEASED
Indicate the record(s) to be released to the receiving entity. Please check only those boxes that apply and be as specific as possible to make sure only those you want to be disclosed are released.

DATES OF CARE: ☐ **Any and all dates** ☐ **Specific dates** _____ **to** _____

☐ Entire Record	☐ Clinic Notes	☐ Consultation Reports
☐ Discharge Summary	☐ EEG / EMG	☐ EKG / Cardiology
☐ Emergency Dept	☐ History and Physical	☐ Substance Use
☐ Immunization Record	☐ Laboratory	☐ Mental Health
☐ Operative/Procedure Report	☐ Pathology Reports	

☐ Tests Results (specify which results): _____

☐ Other (specify information to be released): _____

PURPOSE OF RELEASE **Indicate the reason you are requesting the release of the records. Please check all that apply.**	☐ Continued Care ☐ Insurance ☐ Legal ☐ Moving ☐ Personal ☐ Transferring Care ☐ Treatment, Payment, and Healthcare Operations ☐ Other: _____
FORMAT	The records will be released in a secure electronic format unless otherwise requested. To request an alternative format, contact (515) 282-2482.

*****SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW*****
PLEASE CHECK EITHER YES (RELEASE) OR NO (DON'T RELEASE) IN EACH APPLICABLE LINE AND SIGN BELOW

Substance Use/Abuse ☐ YES ☐ NO Mental Health ☐ YES ☐ NO

HIV/AIDS related information ☐ YES ☐ NO

_____
SIGNATURE OF PERSON OR LEGAL REPRESENTATIVE Date/Time

_____
Relationship To Patient If Not Signed By Patient

Effect: If HIPAA covered entities and business associates receive these records for treatment, payment, and healthcare operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings.

CONDITIONING PROHIBITED: Broadlawns Medical Center will not condition treatment, payment, or enrollment / eligibility for benefits on signing this authorization.

EXPIRATION: This authorization is effective for one year from the date on which it was signed unless otherwise specified here:

_____

REVOCATION: You may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving a written notice to Broadlawns Medical Center, Attn: Medical Records 1801Hickman Road, Des Moines, IA 50314.

INSPECTION: You have the right to inspect the information disclosed upon the proper notification to and under appropriate conditions established by Broadlawns Medical Center.

FEE: Broadlawns Medical Center may charge a fee to cover the cost of labor, copying, and preparation of the requested information.

RE-RELEASE: Recipients of this information may possibly re-release the information without proper authorization and once information is disclosed it may no longer be protected by federal privacy regulations.

PATIENT STATEMENT
By signing below, I acknowledge that I have read, understood, and agree to the terms of this Authorization and I authorize this disclosure. I also acknowledge receipt of a copy of this Authorization.

_____
Patient or Legal Representative Signature Date/Time

_____
Printed Name of Patient or Legal Representative

_____
Relationship to Patient If Not Signed by Patient

PROHIBITION OF REDISCLOSURE
This form does not authorize re-disclosure of medical information beyond the limits of this consent. 42 CFR Part 2 prohibits unauthorized use or disclosure of substance use disorder records. Where information has been disclosed from records protected by federal law for substance use disorder records or by state law for mental health and HIV/AIDS test results, federal law at 42 CFR Part 2 and state law at Iowa Code chapters 228 and 141A prohibit further disclosure without the specific written consent of the patient or as otherwise authorized by law. 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 patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.