AUTHORIZATION TO RELEASE INFORMATION

Name of Patient: _____ Date of birth: _____

I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE

I authorize *the City of Tipton, D.B.A. Tipton Ambulance Service or Tipton EMS* whose address is *407 Lynn ST, Tipton, IA 52772* to disclose and deliver to _____ whose address is _____, the following information: _____.

NOTE: If information includes mental health treatment, substance abuse treatment or HIV-related information it will not be released unless you agree 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) on or about _____.

This authorization 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.

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 the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed 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 redisclose said information to:

A) Parties and their legal counsel, insurers, experts, potential experts, anyone against 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; OR INSTEAD

B) ___ [CHECK ONLY IF APPLICABLE] ONLY to the following:

_____

_____

_____

This Authorization is subject to any protections under Iowa law, including, but not limited to, Iowa Code Section 622.10(3).

I SPECIFICALLY AUTHORIZE AND CONSENT TO THE DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

_____ _____
Signature of Patient or patient's legal representative Date

_____
Printed name and relationship of patient's legal representative

II. AUTHORIZATION FOR CONSULTATION

I understand that if the person or entity listed above is a physician, surgeon, physician's assistant, advanced registered nurse practitioner or mental health professional (provider) this authorization also permits _____ [insert name of attorney requesting consultation] to consult with that provider about my medical history and condition relating to my claims described above, and further permits that health professional to render opinions regarding the cause of my condition and the prognosis for that condition. I understand that if the lawyer seeking consultation represents a party adverse to me, that lawyer shall provide a written notice to my lawyer and other counsel consistent with the Iowa Rules of Civil Procedure for service of a notice of deposition at least ten (10) days prior to such consultation.

In order for the above consultation to be authorized, sign here and at the end of Section I.

_____ _____
Signature of Patient or patient's legal representative Date

_____
Printed name and relationship of patient's legal representative

III. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, AIDS-RELATED INFORMATION, OR GENETIC-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, and/or genetic-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:

_____

_____

____ Mental Health Information from:

NOTE: You have the right to inspect the disclosed mental health information at any time.

_____

_____

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

_____

_____

____ Genetic testing, profiles, counseling, services, education, and medical histories which focus on genetically related diseases or conditions information, diagnosis, and test results from:

_____

_____

_____ _____

Signature of Patient or patient's legal representative Date

_____

Printed name and relationship of patient's legal representative

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidential information to all of the persons referred to in Redisclosure Section I.

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

If mental health information is being disclosed, I acknowledge receipt of a copy of this Authorization.

_____ _____

Signature of Patient or patient's legal representative Date

_____

Printed name and relationship of patient's legal representative

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 patient.

See also Chapter 228 and Chapter 141(A) of the Iowa Code and other applicable laws.

NOTE: PHOTOCOPY OF THIS SIGNED AUTHORIZATION SHALL BE AS EFFECTIVE AS THE ORIGINAL.

TIPTON EMS PATIENT INFORMATION RELEASE PROCEDURE

Updated 3/24/2022

- ☐ ***Note:*** **Medical Records are exempt from Iowa Open Records Laws and Freedom of Information Requests** *Unless:*
  - A Court order (subpoena) signed by a judge has been provided to the records custodian
    - This cannot be from the county attorney or from the clerk of courts
  - For Open Records Requests, please utilize the City of Tipton Open Records Form
- ☐ **Utilize PCC first whenever possible 1-866-332-5335**
- ☐ The requesting party must complete the attached Authorization to Release Information form unless:
  - The patient can reasonable identify themselves to the staff using
    - Name
    - DOB
    - Address
    - SSN
    - AND insists on not filling of the paperwork. THIS MUST BE DOCUMENTED

- ☐ Attach a photocopy of personal identification used to verify patient/ guardian identification

- ☐ The requesting party may identify which format they wish to have their PHI provided to them (within reason)
  - **Fax** Fax Number: _____ (Use Cover Sheet)
  - **Email:** Email Address: _____
    - Electronic Format of Patient Records will be PDF
  - **In Person** ***A reasonable amount to obtain the patient records will be required***
    - Obtain patient phone number if they need to return to pick up record(s)

    Phone Number: _____
  - **Mailed:**

    _____
    Name

    _____
    Address

    _____
    City State Zip Code

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- ☐ Upload copies to patient records:
  - This form
  - The Authorization to Release Information form
- ☐ Document Patient Information Release: NAS \\SCANS\Records Requests\Tipton Ambulance Records Request\

TIPTON EMS PATIENT INFORMATION RELEASE PROCEDURE

Updated 3/24/2022

Patient Health Information Contents that can be disclosed

1. Ambulance or First Responder Trip Sheets
2. Itemized Patient Billing
3. Labs/ X-Rays/ Imaging
4. CAD Sheets

Patient Health Information Contents that WILL NOT be released

1. Continuous Quality Improvement Documentation/ Notes
2. Notes forwarded to our agency by a mental health professional (psychiatrist, psychologist, and licensed professional counselors) **The Requester must go direct to the mental health professional**
3. Department of Health and Human Services Dependent Adult or Child Abuse Reports
4. Reports with other persons PHI (This may be redacted)

1. By law, the City of Tipton must notify you that it grants or denies a request for access to government records within twenty (20) business days after the agency custodian of records receives the request. If the record requested is not currently available or is in storage, the custodian will advise you within twenty (20) business days after receipt of the request when the record can be made available.
2. You may be denied access to a government record if your request would substantially disrupt agency operations and the custodian is unable to reach a reasonable solution with you.
3. If the City of Tipton is unable to comply with your request for access to a government record, the custodian will indicate the reasons for denial on the request form or other written correspondence and send you a signed and dated copy.

Items Released:

Example Tipton Ambulance Run Chart 21-028165

Printed Name of Person Completing this form: _____