Authorization for Release of Medical Information / Right of Access Request

This form authorizes and consents to the disclosure of medical information by Care Initiatives. Please complete this form in its entirety and ensure that all blanks are filled in. Missing information could prevent or delay processing. Return the completed form to Records@CareInitiatives.org or Care Initiatives, Attn: Medical Records Requests, 1611 West Lakes Pkwy., West Des Moines, IA 50266.

Requesting Person/Entity

☐ Resident/Patient ☐ Legal Representative of Resident/Patient* ☐ Other

*(*Attach documentation regarding authority to act on behalf of resident/patient)*

Resident/Patient Information

Resident/Patient Name:_____ Date of Birth:_____

Care Initiatives Location(s):_____

Recipient Information

I am requesting Care Initiatives to release records to the person/entity listed below.

Person/Entity:_____ ☐ *Please check here if you are requesting your own records*

Email:_____ Phone: _____

Mailing Address:_____

Information To Be Released

☐ Legal medical record ☐ Billing records ☐ Care plan ☐ Progress notes ☐ Other:_____

Dates of Service From: _____To: _____

(If no dates listed, records will include the past 12 months prior to the date of signature below)

Information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, AIDS-related information, and/or genetic-related information unless I specifically deny the release. **Please check beside any category you DO NOT want to be released:**

☐ Substance Abuse (Drug or Alcohol)* ☐ Genetic Information** ☐ Mental Health ☐ AIDS Related Information

*Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records).
**Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions

Method of Delivery (select one)

☐ Secure email link ☐ Password-protected flash drive ☐ Paper *(mailed to the address above)*

Purpose of Release (select all that apply)

☐ Continuity of care ☐ Insurance coverage ☐ Social security/disability ☐ Personal use ☐ Legal ☐ Other:_____

This authorization is voluntary. Care Initiatives will not condition treatment or payment on whether a resident/patient signs this authorization. This authorization will expire two years from the date signed, unless revoked sooner. This authorization can be revoked at any time, except to the extent that action has already been taken in reliance upon it. It may be revoked by sending written notice to Care Initiatives at the address listed at the top of this form. Once disclosed, information may be re-disclosed by the recipient and may no longer protected.

_____ _____

Signature of Resident/Patient or Requestor Date

_____

Printed Name & Relationship to Resident/Patient