Spencer Hospital
1200 First Ave. East
Spencer, Iowa 51301
712-264-6198

ROI

Authorization - Release Of Medical Records Information

Patient Identification

Patient name: _____ Date of birth: _____
Address: _____ City/state/zip: _____
Social Security Number (last 4 digits): _____ Phone: _____

Provider
(Who is releasing information?)

The following individual or organization is authorized to make the disclosure:
Provider name: _____
Address: _____ City/state/zip: _____
Phone: _____ Fax: _____

Disclose Information to
(Where is information to be sent?)

Name/facility: _____
Address: _____ City/state/zip: _____
Phone: _____ Fax: _____

Information to be Disclosed

☐ Standard chart copy (Includes Demographic Face Sheet, Physician Dictated Reports, All Test Results)
☐ X-ray and imaging reports ☐ Entire record (charges may apply) ☐ Other _____

Service Dates

Dates of service from (date) _____ to (date) _____

Form and Format

☐ Paper (pickup or mail) ☐ Fax ☐ Flash Drive ☐ CD-ROM (compact disc) ☐ E-mail (please provide address below)

E-mail address: _____
All medical records requested in electronic format will be encrypted unless specifically requested otherwise by the patient. Sending medical records unencrypted has risks including the individual's PHI could be read or otherwise accessed by a third party. File size may limit ability to send by e-mail.

If you want your records sent unencrypted please initial here: _____

Substance Abuse Documentation

Check this box ONLY if you permit substance abuse records to be released.
☐ Requestor, take note: These released records contain substance abuse documentation, and therefore prohibition on redisclosure applies. THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISION OF FEDERAL STATUTES (42 U.S.C. 290dd-2, and regulations 42 CFR, Part 2) which prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Purpose of Disclosure

☐ Continued healthcare ☐ Completion/payment ☐ Personal ☐ Other _____

Expiration Date

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
_____.
If I fail to specify an expiration date, event, or condition, this authorization shall be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.

Revocation

I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to:
- Information already released in response to this authorization
- My insurance company when the law provides my insurer with the right to contest a claim under my policy.

Authorization

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the HIMS department at 712-264-6147.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Date: _____ Information sent: _____