PF-3100

Authorization of Use and Disclosure of Protected Health Information

Peoples Community Health Clinic, 905 Franklin St., Waterloo, IA 50703 (319) 874-3000 Fax (319) 874-3411
Peoples Clinic Butler County, 118 S. Main St., Clarksville, IA 50619 (319) 278-9020 Fax (319) 874-3179

Patient Name: _____ **Date of Birth:** _____

Information to Be Used or Disclosed Information covered by this authorization includes:

Purposes of Disclosure Information listed above will be disclosed for the following purposes:
_____ At the request of the individual _____ Continued Care _____ Other (explain below)

_____

Persons/Entity Authorized to Disclose Information Information listed above will be used or **disclosed by**:

☐ _____
Name(s)/address of person/organization
☐ Peoples Community Health Clinic, 905 Franklin Street, Waterloo, IA 50703
☐ Peoples Clinic Butler County, 118 S. Main Street, Clarksville, IA 50619

Persons/Entity to Whom Information May Be Disclosed Information described above may be **disclosed to**:

☐ _____
Name(s)/address of person/organization
☐ Peoples Community Health Clinic, 905 Franklin Street, Waterloo, IA 50703
☐ Peoples Clinic Butler County, 118 S. Main Street, Clarksville, IA 50619

Format Requested: ☐ **Paper** ☐ **Electronic** (CD) $5.00 payment required at time of request

This authorization automatically expires 365 days from the date this authorization is signed by the patient unless revoked or terminated by the patient or patient's personal representative or otherwise noted here: ____/____/____.

You may revoke or terminate this by submitting a written revocation to Peoples Community Health Clinic. You should contact the Privacy Officer to terminate this authorization.

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

You may inspect or copy information that is used or disclosed under this authorization. You may refuse to sign this authorization. If you refuse to sign this authorization, we will not deny you any treatment that is covered by your general consent to the use and disclosure of protected health information for purposes of treatment, payment, or supporting the day-to-day operations of this clinic. If you refuse to sign this authorization, you may not be eligible for, or receive, research-related treatment or treatment that you have requested for the purpose of disclosure to others.

Peoples Community Health Clinic may receive payment for disclosures permitted by this authorization.

I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (initial any category not to be released).

Substance Abuse** _____ Mental Health _____ HIV-Related Information _____

***This information has been disclosed to you from records protected by federal confidentiality laws and regulations regarding substance abuse treatment program records (42 C.F.R. Part 2 prohibits unauthorized disclosure of these records).*

I understand that my health records at Peoples Community Health Clinic, Inc. are integrated medical, HIV, mental health, and substance use disorder information. Therefore, I understand if I deny release of these categories, my records may not be sent.

Signatures:

_____
Patient or Legal Representative (if representative, please print relationship) Date

_____
Witness Date

OFFICE USE ONLY: PCHC # 201E ☐ GET FROM **WHITE** - PCHC ☐ SEND TO **CANARY** – Agency/Person ☐ FILE ONLY **PINK** – Client ☐ PMT REC'D Rev 01/20