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:

Write in what part of the chart you want a copy of or what you want disclosed to the other party.

Also Include: Our records are integrated with the following information. If you do not mark "Yes," your record request may be denied.

HIV Information ☐ yes ☐ no Signature _____

Mental Health Information ☐ yes ☐ no Signature _____
(Only client 18 yrs. of age or older or legal representative can authorize release of mental health information.)

Substance Abuse Treatment and Assessment Information ☐ yes ☐ no Signature _____
(Only client, regardless of age, can authorize release of substance abuse information.)

This information has been disclosed to you from records protected by Federal laws and regulations protecting substance abuse treatment program records (42 C.F.C. part 2). The Federal rules that prohibit you from making any further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for the purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Purposes of Disclosure Information listed above will be disclosed for the following purposes:
_____ At the request of the individual _____ Continued Care _____ Other (explain below)
Mark "At the request of the individual" if this is for you. "Continued Care" if it is for another doctor. "Other" if for anyone else and then explain.

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

☐ If you want records from a different doctor to be sent to Peoples Clinic, put the doctor's name and address here and mark the box.
Name(s)/address of person/organization
☐ Peoples Community Health Clinic, 905 Franklin Street, Waterloo, IA 50703 If you want your records from Peoples Clinic to
☐ Peoples Clinic Butler County, 118 S. Main Street, Clarksville, IA 50619 be sent to someone else, mark one of these.

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

☐ If you want records from Peoples Clinic to be sent to someone else, put the name and address here and mark the box.
Name(s)/address of person/organization
☐ Peoples Community Health Clinic, 905 Franklin Street, Waterloo, IA 50703 If you want your records from another doctor to
☐ Peoples Clinic Butler County, 118 S. Main Street, Clarksville, IA 50619 be sent to Peoples Clinic, mark one of these.

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.

Signatures:

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

_____
Witness Date

OFFICE USE ONLY: ☐ GET FROM ☐ SEND TO ☐ FILE ONLY ☐ PMT REC'D
PCHC # 201E **WHITE** – PCHC **CANARY** – Agency/Person **PINK** – Client Rev 09/18