CONSENT TO OBTAIN INFORMATION

University of Iowa Student Health Service

Please PRINT (except signatures) and provide complete information in each section.

Patient Name _____ Birth Date _____ Student ID # _____

I, the undersigned, hereby authorize:

_____
Name of Person and/or Institution

_____
Complete Mailing Address/Street/P.O. Box

_____
City, State, Zip Code

to release medical information concerning the above named patient to:

University of Iowa Student Health Service
4189 Westlawn
Iowa City IA 52242-1100

ATTENTION:

_____
First Name Last Name

☐ **Information checked below is for <u>phone release</u> only. Phone number:** _____

Check the information to be disclosed (include dates where indicated): ☐Minimum necessary or specify

☐ Entire Record
☐ Medication list ☐ Allergy list ☐ Immunization record
☐ Most recent history and physical or specify date(s) _____
☐ Clinical notes related to visit(s), specify visits or date(s) _____
☐ Test results (i.e. lab, X-ray, EKG, etc.), specify type and date(s) _____
☐ Billing information, specify _____
☐ Other, specify _____

As per my request, the reason for release of information is: ☐ medical care ☐ legal ☐ insurance
☐ Other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Director of Medical Records, University of Iowa Student Health Service, 4189 Westlawn, Iowa City, IA 52242-1100. I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Medical Records at the above address.

I understand that the University of Iowa Student Health Service may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in a denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (***<u>initial</u>*** any category ***<u>not</u>*** to be released).

Substance Abuse _____ Mental Health _____ HIV-related information _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____

_____
Signature of Patient or Legal Guardian Date

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____
Relationship, if Not the patient

_____
Witness Signature

SHS use only:
Form Sent: _____
Name Date

Original – medical record
Copies – deliver as requested above
- to patient