University of Iowa
Student Health Service

Name _____

Birth Date _____

Student ID#_____

Authorization for Release of Information and Payment Request

I. Insurance, payment information and assignment of benefits

- I request The University of Iowa Student Health Service (SHS) to submit claims on my behalf to my insurance company, Medicare, or other third party payor for my care and authorize disclosure of health information to the extent necessary to obtain payment.
- In consideration of the health care services provided to the Patient, I assign and authorize my insurance company, Medicare, or other third party payor to make payments directly to SHS including charges for physician services.
- I have been informed that:
  - I must pay all charges, co-payments, deductibles, and coinsurance not covered by my insurance company, Medicare, or third party payor, and these will be charged to my UBill.
  - I must pay all charges incurred if I lack insurance coverage and will also contact SHS to work with them to identify financial options available for me.
  - The policy holder of my health insurance may receive information pertaining to my visits.
  - I may revoke this consent to release medical information at any time by sending a written notice to Student Health Service, 4189 Westlawn, University of Iowa, Iowa City, Iowa 52242. Except as provided below * this release is valid until revoked.
- I authorize SHS to share my third party payor information with The University of Iowa Hospitals and Clinics.
- I agree to pay for non-covered services or services not covered as a result of my failure to obtain pre-authorization for treatment as required by any such payor, or agreed upon services deemed as medically unnecessary by the payor.
- SHS will use good faith efforts to protect patient's right to confidentiality in appropriately providing health information to payors.

II. Specific Authorization for Release of Information

I specifically authorize SHS to submit medical information regarding diagnoses, treatment, consultations, prescriptions, and medical history to my insurance company, Medicare, or other third party payor or its authorized agents or representatives for the purpose of determining benefits and facilitating payment. This authorization is valid for one (1) year*. Disclosures may only be made pursuant to the written authorization of an individual or an individual's legal representative. The unauthorized disclosure of this information is unlawful and civil damages and criminal penalties may be applicable to the unauthorized disclosure of said information pursuant to the Iowa code. I may revoke this specific consent to release information at any time by sending a written notice to Student Health Service, 4189 Westlawn, University of Iowa, Iowa City, Iowa 52242. I understand that the information to be released may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).

_____ **Substance Abuse**

_____ **Acquired Immune Deficiency Syndrome (AIDS) including Human Immuno-deficiency Virus (HIV)**

_____ *** Mental Health (valid for two years)**

_____ _____ _____
Patient Signature/Responsible Person | Date Signed | Relationship/Legal Title (if not patient)

(If patient is greater than or equal to 18 years old, patient must sign. If patient is less than 18 years, legal guardian must sign)

_____ _____ _____ _____
Witness | Date Signed | Witness | Date Signed

University of Iowa
Student Health Service
INSURANCE INFORMATION

Name _____

Birth Date _____

Student ID#_____

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

I. Primary Policyholder Information:

Name of Policyholder: _____
Address of Policyholder: _____
(Street) (City) (State) (Zip)
Phone of Policyholder: (_____) _____--_____
Birth Date of Policyholder: _____/_____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Partner ☐ Father ☐ Mother ☐ Other_____

Primary Insurance Information:

Insurance Company: _____
Address of Insurance Co: _____
Phone Number(s): (_____) _____--_____; (_____) _____--_____
Policy Number: _____
Group Number: _____
Employer of Policyholder: _____

****Do you have other health insurance?** ___Yes ___ No If yes, please complete the following information:

II. Secondary Policyholder Information:

Name of Policyholder: _____
Address of Policyholder: _____
(Street) (City) (State) (Zip)
Phone of Policyholder: (_____) _____--_____
Birth Date of Policyholder: _____/_____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Partner ☐ Father ☐ Mother ☐ Other_____

Secondary Insurance Information:

Insurance Company: _____
Address of Insurance Co: _____
Phone Number(s): (_____) _____--_____; (_____) _____--_____
Policy Number: _____
Group Number: _____
Employer of Policyholder: _____

WE RECOMMEND THAT YOU HAVE YOUR INSURANCE CARD WITH YOU AT SCHOOL

Return this form to: Student Health Service University of Iowa 4189 Westlawn Iowa City, IA 52242-1100