RCH Ringgold County Hospital
An Affiliate of MERCYONE

Ringgold County Hospital – Mount Ayr Medical Clinic
504 N. Cleveland Street
Mount Ayr, IA 50854

Main Phone: (641) 464-3226
Mount Ayr Medical Clinic Fax: (641) 464-4476
Ringgold County Hospital Fax: (641) 464-4436

Authorization for Request of Medical Information

To: (*Please Print*)

Clinic Name:	Attention to:
Phone Number:	Fax Number:

Regarding: Patient Information (*Please Print*)

First Name: Middle Initial: Last Name:			
Date of Birth (MM/DD/YYYY):	Phone:		
Street Address:	City:	State:	Zip:

Type of Records requested? *(Check appropriate boxes below):*

☐ Office visits, last 3 years ☐ Laboratory results, last 3 years ☐ Radiology results, last 3 years

☐ Vaccine records ☐ Colonoscopy/pathology, most recent ☐ Pap smear/pathology, most recent

☐ Mammography, past 5 years ☐ Other _____

☐ Hospitalization discharge summary, most recent ☐ Copy of entire medical record, as by law

☐ All medical records related to a specific injury or illness _____

Purpose of this request: *(Check appropriate boxes below*):

☐ Transfer of care ☐ Insurance Coverage ☐ Healthcare ☐ Other _____

How do you want to receive this request: *(Check appropriate box below*):

☐ Mail ☐ Email ☐ Pick up at front desk ☐ Fax

Authorization Valid for: *(Check appropriate box below will default to 'this request only' if nothing marked*):

☐ This request only. ☐ One year from the date of this authorization

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: *(check box, initial and sign/date)*

_____☐ Mental Health Treatment _____☐ Drug and/or Alcohol Abuse Treatment _____☐ HIV/AIDS test results

_____ _____

Signature of Patient or Authorized Representative Date

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Director of Health Information at Ringgold County Hospital or Mount Ayr Medical Clinic.
I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Ringgold County Hospital or Mount Ayr Medical Clinic.
I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.
I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations, I understand this authorization is voluntary.

_____

Signature of Patient or Patient's Authorized Representative

_____ _____

Date Relationship to Patient

_____

Witness Date

PROHIBITION OF REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, and HIV/AIDS test results, federal requirements (42-CRF, Part 2) and state requirements (Iowa Code ch. 228 & ch. 141) prohibit further disclosure without the specific written consent of the patient or as otherwise permitted by such law or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information related information or HIV/AIDS test results.

Request Received _____ *Request Completed* _____
Initial/Date *Initial/Date*