AUTHORIZATION TO RELEASE INFORMATION[1]

Patient Name_____ D.O.B._____/_____/_____ SSN #_____/_____/_____

I authorize_____
Name Address

To disclose the information described below to

_____
Name Address

Specific description of information (including date(s) of service)
If information includes mental health treatment, substance abuse treatment or HIV-related information it will not be released unless the reverse side of this form is completed.

_____

_____

_____

The disclosure is for the following purpose(s)_____

_____
If the disclosure is at the request of the patient, then indicate on the line above, or specify other purpose (i.e., marketing; research)

This release is for marketing purposes and Prairieland Eye Clinic is being compensated for the disclosure by _____

_____
Strike the above provision if not applicable.

This release expires on _____/_____/_____ or one year from the date signed.

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services unless the services are at the request of the party to whom the protected health information will be disclosed. I also understand that if I revoke, the revocation will take effect on the day it is received in writing as explained in our notice of privacy practices as provided to you.

I further understand that, except in the case of substance abuse, mental health, or AIDS-related information, if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not a business associate of these entities, the information described above may be redisclosed and will no longer be protected by the regulations.

_____ Date_____/_____/_____
Signature of Patient or Patient's Legal Representative

Printed name of patient's legal representative_____

Relationship to the patient_____

[SIDE A]

[1] This authorization was drafted to comply with the Federal HIPAA privacy rule and applicable Iowa law.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, OR AIDS-RELATED INFORMATION

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to [write YES or NO in ALL applicable boxes]

_____ Substance abuse (drug or alcohol) information from:

_____ Mental health information from:

_____ AIDS-related information, diagnosis, and test results from:

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidental information to all of the persons referred to.

In order for the above information to be released, you must sign here AND on the reverse of this form.

_____ Date_____/_____/_____

Signature of Patient or Patient's Legal Representative

Printed name of patient's legal representative_____

Relationship to the patient_____

Note to provider:
Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, or mental health, or AIDS-related information must be accompanied by the following written statement:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorizationf or the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
>
> See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

[SIDE B]