IOWA STATE UNIVERSITY
Thielen Student Health Center

2647 Union Drive
Ames, Iowa 50011
Phone: 515-294-5801
Fax: 515-292-9135

Authorization for Release of Healthcare Information

Patient Information:

Patient Name (Last, First, Middle, Maiden):	
Current Address (including City, State, Zip):	
University ID#	Date of Birth (MM/DD/YYYY)
Phone #:	Email Address:

I hereby authorize written and/or verbal RELEASE of my healthcare information as indicated:

Release Information FROM		**Release Information TO**	
Name:		Name:	
Address:		Address:	
City, State ZIP:		City, State Zip:	
Phone:	Fax:	Phone:	Fax:
Email:		Email:	

Please send my records by: ☐ Mail ☐ Fax ☐ Secure Email

INFORMATION REQUESTED:	**REASON FOR RELEASE:**
☐ Immunizations/titers/TB testing results: ☐All ☐ Specific Immunizations:	☐ Continuing/transfer of care
☐ X-ray dates/condition: ☐ X-ray report (no images) ☐ X-ray image (CD)	☐ Legal/attorney
☐ Lab(s) dates/condition	☐ Insurance purposes
☐ Billing information dates:	☐ Personal use
☐ Physical Therapy dates/condition:	☐ Other (specify):
☐ Other (specify):	☐ Upcoming Appt:
☐ My complete medical records from/to the following date(s): **OR** about the following condition(s):	

PLEASE READ: ADDITIONAL AUTHORIZATION REQUIRED: I authorize, **with my initials**, the release of the following types of records:

Substance Abuse_____ Mental Health_____ HIV/AIDS_____ Sexual Assault Exam information _____

NOTE: Patients who believe these record types do not pertain to them may still choose to initial above to expedite the record release process. If you choose not to initial, your record must be reviewed in detail to determine if these record types are present. This review and redaction process can take up to 30 business days. *Pursuant to Iowa law, TSHC may disclose substance abuse and mental health records (but not HIV/AIDS or sexual assault exam information) to another healthcare provider for continuation or transfer of care without your express consent if not otherwise restricted by federal law or regulation, or as otherwise defined in our Notice of Privacy Practice (NPP).*

I have read the above and have initialed by the types of records I authorize to include with this ROI_____(initial here)

Further, I agree and understand:

1. This authorization may be revoked at any time by notifying TSHC in writing except to the extent that action has been taken in reliance on it.
2. I can request an accounting of disclosed information by writing to the TSHC Health Information Privacy Officer at the address above.
3. My refusal to sign, or revocation of, this authorization will not affect my ability to obtain healthcare services from TSHC.
4. The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy rules.
5. There may be a fee associated with the copying of records.
6. In accordance with federal law, TSHC may take up to 30 days to process this request and release my records.
7. This agreement will expire one year from the date of signature below, unless previously revoked or otherwise indicated here: _____

Patient's Printed Name

Today's Date (MM/DD/YYYY)

Signature of Patient (or Legal Representative, if applicable)

If applicable, Legal Representative's Printed Name and Relation to Patient (e.g., Mother, Father, Guardian, etc.) or signature of witness (witness not required in Iowa, but may be in other states).

☐ **Terms of Acceptance and Signature**: I accept and understand that by typing my name here, I am signing this Agreement electronically. I agree and understand that my electronic signature is the legal equivalent of my handwritten signature and that I am legally bound by the terms contained in this document.

Rev: 03-22

☐No patient initials required: care coordination/transfer of care ☐Records sent: Date_____ Staff initials_____