Print Form

AUTHORIZATION TO RELEASE INFORMATION

Name of Patient: _____ Date of birth: _____

I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE

I authorize _____ whose address is

_____to disclose and deliver to

Iowa Municipalities Workers' Compensation Association, whose address is 317 Sixth Avenue, Des Moines, IA 50393-3688, the following information: **any and all medical records, including those predating the date of injury and initial patient questionnaire**
NOTE: *If information includes mental health treatment , substance abuse treatment or HIV-related information it will not be released unless you agree to the release on the reverse side of this form.*

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against and/or arising out of incident(s) on or about .

This authorization expires on , (not to exceed one year); or, if no date is specified, on the termination of the litigation or other proceedings for which this authorization was provided.

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. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from whom disclosure is sought in writing.

I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and/or Federal law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I further understand that the Recipient, WITHOUT FURTHER AUTHORIZATION, may redisclose said information to Parties and their legal counsel, insurers, experts, potential experts, anyone against whom claim is or has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any of said persons

I SPECIFICALLY AUTHORIZE AND CONSENT TO THE DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

X _____ _____
Signature of Patient or patient's legal representative Date

Name and relationship of patient's legal representative:

_____

II. AUTHORIZATION FOR CONSULTATION

I understand that if the person or entity listed above is a physician, surgeon, physician's assistant, advanced registered nurse practitioner or mental health professional (provider) this authorization also permits to consult with that provider about my medical history and condition relating to my claims described above, and further permits that health professional to render opinions regarding the cause of my condition and the prognosis for that condition. I understand that if the lawyer seeking consultation represents a party adverse to me, that lawyer shall provide a written notice to my lawyer and other counsel consistent with the Iowa Rules of Civil Procedure for service of a notice of deposition at least ten (10) days prior to such consultation.
In order for the above consultation to be authorized, sign here and at the end of Section.

X _____ _____
Signature of Patient or patient's legal representative Date

Name and relationship of patient's legal representative:

_____

III. 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: [Place "YES" or "NO" in ALL applicable boxes:]

YES Substance Abuse (Drug or Alcohol) Information from:

_____

_____

_____

YES Mental Health Information from: *NOTE: You have the right to inspect the disclosed mental health information at any time*

_____

_____

_____

(Name of agencies, facilities, or individuals)

YES AIDS-related Information, Diagnosis, and test results from:

_____

_____

_____

(Name of agencies, facilities, or individuals)

X _____ _____

Signature of Patient or patient's legal representative Date

Name and relationship of patient's legal representative:

_____

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidential information to all of the persons referred to in the Redisclosure Section I. In order for the above information to be released, you must sign here AND at the end of Section I. If mental health information is being disclosed, I acknowledge receipt of a copy of this Authorization.

X _____ _____

Signature of Patient or patient's legal representative Date

Name and relationship of patient's legal representative:

_____

Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, 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 authorization for 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 and Chapter 141(A) of the Iowa Code and other applicable laws.