GUTHRIE COUNTY HOSPITAL

An Affiliate of UnityPoint Health

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.

PATIENT: Name: _____ Medical Record Number: _____

IDENTIFICATION: Date of Birth: _____
Parents/Previous name(s): _____

PROVIDER: *(Who is releasing the information sent)*
Name: _____
Address: _____
Phone: _____ Fax: _____

INFORMATION:
☐ Complete Records _____ ☐ Immunization Record _____
☐ Lab Data: Date _____ ☐ X-ray Data: Date _____
☐ EKG: Date _____ ☐ D/C Summary: Date _____
☐ H&P: Date _____ ☐ Other _____

PURPOSE:
☐ Transferring Medical Care ☐ Moving
☐ Insurance Coverage ☐ Other _____

INFORMATION SENT TO:
Name: _____ Phone: _____
Address: _____ Fax: _____
_____

Specific Authorization for Release of Information Protected by State or Federal Law

I understand that this will include health information relating to (check, sign & date if applicable):

- ❑ **HIV (human Immunodeficiency Virus) infection**
- ❑ **Treatment for alcohol and/or drug abuse**
- ❑ **Sexually transmitted diseases**
- ❑ **Mental Health**
- ❑ **Genetic Testing**

Signature: _____ **Date:** _____

Guthrie County Hospital/Clinics will not condition treatment on your signing this authorization, unless: (1) you are receiving research-related treatment; or (2) the only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

This authorization is effective for one year from the date on which it was signed. 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 Guthrie County Hospital/Clinics. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Guthrie County Hospital/Clinics. The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Guthrie County Hospital/Clinics Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Relationship to Patient, if not signed by Patient **Witness**

PROHIBITION OF REDISCLOSURE

Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42.C.F.R. Part 2) and state requirements (Iowa Code ch.228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/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. I understand all other information used and/or disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

(A copy of this signed form will be provided to the patient upon request)

Patient Name: _____ Date Birth: _____ Referred By: _____

Patient Health History

Thank-you for selecting GCH Clinics

As a new patient to our practice, please fill out the information below so we may provide you with the highest level of healthcare.

Past Medical History: Have you ever had the following – **(Please circle either yes or no)**

Diabetes	Yes	No		Measles	Yes	No		Headaches	Yes	No		Lung Disease	Yes	No
Cancer	Yes	No		Mumps	Yes	No		Tuberculosis	Yes	No		Stroke	Yes	No
High Blood Pressure	Yes	No		Chickenpox	Yes	No		Blood Transfusion	Yes	No		Heart Valve Disease	Yes	No
Asthma	Yes	No		Scarlet Fever	Yes	No		Hernia	Yes	No		Anemia	Yes	No
Allergies	Yes	No		Pneumonia	Yes	No		Glaucoma	Yes	No		Hepatitis	Yes	No
Stomach Ulcer	Yes	No		Rheumatic Fever	Yes	No		Hemorrhoid	Yes	No		Blood Clots	Yes	No
Anxiety or Depression	Yes	No		Sexually Trans. Disease	Yes	No		Spine Trouble	Yes	No		Bleeding Tendency	Yes	No
Thyroid Disease	Yes	No		Urine Infections	Yes	No		Hives / Eczema	Yes	No		Other Diseases:		
Heart Disease	Yes	No		Epilepsy/Seizure	Yes	No		AIDS / HIV+	Yes	No				
Arthritis	Yes	No		Sleep Apnea	Yes	No		Kidney Disease	Yes	No				

Previous Surgeries: (Please List) _____

(Examples include: Tonsils, Back, Hernia, Appendix, Gall Bladder, Cervix, Colon, etc.)

Medications: (include non-prescription)

Name of Medication	Strength	How Often		Name of Medication	Strength	How Often

Allergies to Medications: _____ **Allergies to Other: _____**

Routine Immunizations: (Please indicate the year in which you last had the following)

Tetanus Shot _____ Flu Shot _____ Hepatitis B Shot _____ Meningitis Shot _____

Varicella (chicken pox) Shot _____ Pneumonia Shot _____ Zostavax (shingles) Shot _____ HPV Shot _____

Routine Screenings: (Please indicate the year in which you last had the following and any abnormalities)

Eye Exam _____ Dental Exam _____ Bone Density (DEXA) _____ Colonoscopy _____

PSA test (men only) _____ Pap Smear (women only) _____ Mammogram _____

Female Patients Only: Menses: Age Onset _____ How Often _____ Last Menstrual Period _____

Pregnancies: Number _____ Living Children _____ Miscarriages _____ Abortions _____

Social History:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	Drinks per day: _____
Use of Tobacco:	Never	Previously, but quit		Current	Packs per day: _____
Use of Drugs:	Never	Current	Type / Frequency _____		
Caffeine:	Never	Current – type/frequency per day _____			
Exercise:	Never	Current – type / frequency per week _____			

Family Medical History:

	Age	Diseases	If Deceased, Age and Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

GCH Clinics
Patient Demographic Information

Patient Name: _____ Birthdate: _____ Sex ___M ___F
Social Security Number: _____ Marital Status: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

Spouse/Parent Name: _____
Spouse/Parent Employer: _____ Work Phone: _____

Emergency Contact (not at same address): _____ Phone: _____
Relationship to Patient: _____

How were you referred to us?
____ Internet _____ Phone Book _____ Friends/Family _____ Newspaper ____ Radio ____ Other _____

Insurance Information

See Copied Cards: _____
Primary Insurance Company: _____ Effective Date: _____
Primary Subscriber Name: _____ Subscriber Date of Birth: _____
Subscriber Social Security Number: _____
Insurance Group Number: _____ Insurance Policy Number: _____

Secondary Insurance Company: _____ Effective Date: _____
Primary Subscriber Name: _____ Subscriber Date of Birth: _____
Subscriber Social Security Number: _____
Insurance Group Number: _____ Insurance Policy Number: _____

Authorization

Responsible for Payment: If insurance payment of legal settlement is involved in the problem for which the patient is seeing the physician, I understand that I am personally responsible for the amount not covered by insurance or legal settlement.

Authorization for Release of Information: I hereby authorize the release of any information necessary in the course of my examination, treatment, or the process of a claim.

Authorization to Pay Benefits: I hereby authorize payment to GCH Clinics of all medical and/or surgical benefits.

Medicare Authorization: I request that payment of authorized Medicare benefits be made either to me or on my behalf to GCH Clinics for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ Date: _____

Notice of Health Information Privacy Practices

By signing below, I acknowledge that I have received a copy of the "Notice of Health Information Privacy Practices" for Guthrie County Hospital and its Organized Health Care Arrangement:

Signed: _____ Date: _____