University of Iowa Health Care

UI Sports Medicine

2701 Prairie Meadow Drive
Iowa City, Iowa 52242
319-384-7070 ***Tel***
www.uihc.org

CONSENT TO RELEASE OF INFORMATION

Hosp. #____________

UI Sports Medicine and University of Iowa Hospitals and Clinics (UIHC)

Please use blue or black ink, neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name ____ **Birth Date** __________________________

By signing this form, I am allowing UIHC and UI Sports Medicine staff to release medical information concerning the above named patient to the person or facility listed below via: _____ Verbal _____ Copies _____ Viewing

___Cedar Rapids Jefferson High School ____________1243 20th St SW _____________ Cedar Rapids, IA 52404 ____
Name of Person and/or Institution | Complete Mailing Address/Street/P.O. Box | City, State, Zip Code

____
Name of Person and/or Institution | Complete Mailing Address/Street/P.O. Box | City, State, Zip Code

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Director of UI Sports Medicine, 2701 Prairie Meadow Drive, Iowa City, IA 52242 or if a UIHC patient the Director of Health Information Management, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, Iowa City, IA 52242. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the individual as above.

UIHC does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services. I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).

Substance Abuse*________ Mental Health _________ HIV-related information _________ Genetic tests/info**________

*Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2 prohibits unauthorized disclosure of these records). **Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This agreement allows release of past and future information and will expire two years from the date of signature, or as indicated (specify number of days or months) ___________________________ unless cancelled by the patient/guardian.

____ ________________________
Signature of Patient or Legal Guardian | Date

____ ________________________
Complete Mailing Address/Street/P.O. Box | City, State, Zip Code

____ ________________________
Relationship, if Not the Patient | Witness Signature

UIHC patients only: *Upon satisfying this release, date & sign; record on the Release of Information Tracking (ROIT) system and scan the form in to Epic.* ***If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, complete the following as appropriate and then forward to the Release of Information Office, Health Information Management (HIM) Department.***

Info. sent: ______________________________ _____________ Recorded on ROIT System: ________________________________ ______________
Name/Department | Date | Operator Name/Department | Date

Non-UIHC patients: Upon satisfying release, date & sign; retain in UI Sports Medicine Clinic or mail to Athletic Training Outreach Coordinator, UI Sports Medicine, 2701 Prairie Meadow Drive, Iowa City, Iowa 52242.

Privacy Notice Acknowledgment Form

By signing this form I acknowledge that I have received the University of Iowa Health Care Privacy Notice. I have the right to review the Privacy Notice prior to signing this acknowledgment form. The Privacy Notice can be found on the web at https://uihc.org/privacy-notice-english or a paper copy can be obtained from the Cedar Rapids Jefferson High School Athletic Office.

University of Iowa Health Care has the right to change the Privacy Notice from time to time. The revised Privacy Notice will be posted within University of Iowa Hospitals and Clinics and Student Health Services facilities, on the University of Iowa Health Care web site, and paper copies will be available at all registration and check-in points.

Patient Name:____**Date**:________

Signature of Patient
or Legal Representative:____

Relationship to the Patient:____

For UIHC Use Only

For failure to obtain acknowledgement, check the appropriate reason:

- ❑ Substantial communication barriers
- ❑ Refusal to sign
- ❑ Other____

Description:

____

____

______________________________________ ______________________________
UIHC Staff Signature: Date:

______________________________________ ______________________________
Department: Title: