UNIVERSITY of IOWA HOSPITALS & CLINICS
University of Iowa Health Care

Institute for Orthopaedics, Sports Medicine and Rehabilitation

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

CONSENT TO RELEASE OF INFORMATION

UIHC Hosp. #_____

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

Please 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 via: copies _____ viewing _____ verbal _____ concerning the above named patient to the following:

Name of Person and/or Institution	Complete Mailing Address/Street/P.O. Box	City, State, Zip Code
Regina Catholic Education Center	2150 Rochester Ave	Iowa City, IA 52245

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.

As 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, those services may not be provided.

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_____

*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 will expire one year 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, 2 SRF.***

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, 170 OSMR, 2701 Prairie Meadow Drive, Iowa City, Iowa 52242.