UIDL
UI Diagnostic Laboratories

CONSENT TO RELEASE OF INFORMATION
University of Iowa Diagnostic Laboratories (UIDL)

UIDL Billing Account # on your UIDL Statement _____

University of Iowa Diagnostic Laboratories (UIDL), 200 Hawkins Dr. 5231 RCP, Iowa City, IA 52242
Telephone: 319-353-7958; Fax: 319-356-0729
Email: UIDL Reference Billing Department uidlreferencebillingdepartment@healthcare.uiowa.edu

This form does not replace any other Consent to Release of Information Form that may or may not be on file within University of Iowa Hospitals and Clinics. This form is for release of information only as it pertains to the billing of reference laboratory services provided to the patient through the UIDL, as ordered by the patient's non-UIHC physician.

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

REQUIRED:

Patient's Legal Name (Last, First): _____ Birth Date: _____
List any previous names (maiden, married, legal changes) _____

Billing Address as shown on a recent UIDL patient statement of charges

_____

_____

By signing this form, I am allowing UIDL to release medical information concerning the above-named patient to the person listed below. Information may be shared by: ___Verbal ___Copies (Copies of paper documents will be provided on paper.)

REQUIRED:

Name of Person (other than patient) who will receive information (Last)_____First)_____

Complete Mailing Address of the person who you are authorizing the release of information to:

Street/P.O. Box_____

City _____ State _____ Zip Code_____

Check the information to be disclosed :

X UIDL Billing Information pertaining to reference laboratory work performed

Please check the reason for release below; and provide a date by which the info is needed:
__Account Payment to UIDL for reference laboratory services performed
__Other (specify)_____

This consent is voluntary. If I cancel this consent later, I must send written notification to University of Iowa Diagnostic Laboratories (UIDL) at the above address. 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 University of Iowa Diagnostic Laboratories (UIDL) at the above address. I have been offered a copy of this authorization.

UIDL 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.

REQUIRED:

_____ _____ _____
Signature of Patient or Legal Guardian | Printed Name | Date

_____ _____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code (if different than listed above)

_____ _____
Relationship, if Not the Patient | Witness Signature