402 10th Street SE, #600
Cedar Rapids, IA 52403
Ph: (319) 298-0953
Fax: (319) 298-0954

202 10th Street SE, #117
Cedar Rapids, IA 52403
Ph: (319) 369-9620
Fax: (319) 826-3558

474 1st Avenue
Coralville, IA 52241
Ph: (319) 351-3930
Fax: (319) 351-3934

730 E. Kimberly Rd
Davenport, IA 52807
Ph: (563) 386-1553
Fax: (563) 391-7702

931 13th Ave North
Clinton, Iowa 52732
Ph: (563) 242-2305
Fax: (563) 242-4212

TRANSFER- AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT IDENTIFICATION:

Patient's Name: ____________________ Patient ID: ____________ Date of Birth: ______________

Address: ____ Phone: ______________________

SENDER/RECIPIENT IDENTIFICATION:

By signing this form, I am allowing the sending facility listed below to release medical information concerning the above-named patient to the receiving facility listed below.

Sending Facility: ____ Phone: ____________________

Address: ____ Fax: ______________________

Receiving Facility: ____ Phone: ____________________

Address: ____ Fax: ______________________

CHECK THE INFORMATION TO BE DISCLOSED: **Date Range:** ____________________ **thru**: ________________________

- ☐ Patient Demographics
- ☐ Physician's Order
- ☐ Sleep Studies
- ☐ Copy of 30 Day Compliance Download
- ☐ Face to Face Clinical Re-Evaluation
- ☐ PT/OT Notes
- ☐ Entire medical record
- ☐ Medical Expense Summary
- ☐ Housing Verification Form
- ☐ Prescription for: ________________________________
- ☐ Initial Date of Service: ____________________________
- ☐ Last Billing Date of Supplies: ______________________
- ☐ Last Billing Date of Equipment: _____________________
- ☐ Make/Model of Equipment: ________________________
- ☐ Serial Number of Equipment: ______________________
- ☐ Insurance That Paid for the Equipment: ______________
- ☐ Patient Medication List
- ☐ Other: _______________________________________

PLEASE CHECK THE REASON FOR THE RELEASE BELOW:

☐ Insurance ☐ Transfer ☐ Legal ☐ Taxes ☐ Other: ______________________________

I UNDERSTAND THAT THE INFORMATION MAY BE RELEASED ELECTRONICALLY AND MAY INCLUDE INFORMATION FROM THE FOLLOWING CATEGORIES IF I HAVE *INITIALED* MY APPROVAL FOR DISCLOSURE BELOW:

- ☐ HIV- or AIDS-Related Information
- ☐ Behavioral/Mental Health
- ☐ Substance Abuse
- ☐ Genetic testing/information (Refers to genetic testing to screen for a possible future health issue; does not refer to testing to diagnose or treat current health conditions)

THIS AUTHORIZATION IS APPROVED FOR (*check one; if no box selected, the release is effective for this occurrence only*):

☐ This occurrence only ☐ 60 days from the date of signature ☐ 1 year from the date of signature

Please read the following statements carefully:

- I understand that I may cancel or revoke this authorization at any time by sending a written notice to the Sending Facility listed above. Upon receipt of the written revocation, we will stop using or disclosing the information, except to the extent that we have already taken action in reliance on the authorization. You may revoke an authorization in writing at any time.
- I understand that authorizing the disclosure of this health information is voluntary. Signing this form is not required. I do not need to sign this form to receive treatment.
- I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations. I also acknowledge that the recipients of this information may possibly re-release the information without proper authorization.
- I understand that requests for records that are not maintained by CarePro Health Services, will need to be made directly to that healthcare provider or facility.
- I understand there may be a reasonable charge to obtain a copy of these records.

☐ **By checking this box you agree that you are electronically signing this form.**

______________________________ ______________________________
Typed Name Date

______________________________ ______________________________
Relationship, if not the patient Witness

Notice to Receiving Person/Agency/Entity: 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. See also Chapter 228 and Chapter 141(A) of the Iowa Code and other applicable laws.

Internal Use Only:
CarePro Employees check the boxes below when *releasing* information:

Fully executed waiver received: _____/______/_______

☐ Identification verified ☐ Copy of signed authorization given to patient ☐ Obtained HCPOA or Court Appt. Document, if necessary & attach

To be sent to Requestor in the following method (*choose one type of record and one method of delivery)*: ☐ Paper copy ***OR*** ☐ Electronic copy

☐ In person ☐ Encrypted Email ☐ Mail ☐ Fax (attach confirmation) ***OR*** ☐ Un-encrypted email requested; requestor warned/accepts risk

CarePro Location Manager or Designee to fill out below:

Released by: ______________________ Date Released: ______________ ☐ Released by methods checked above.
If released by a different method than noted above, indicate method and reason: ______________________
Other notes: ______________________