Camp Albrecht Acres · 2023 Camp Application · Part 2

IOWA HIPAA MEDICAL AUTHORIZATION RELEASE FORM

I, as the camper or camper's legal representative, authorize Camp Albrecht Acres of the Midwest to release and deliver confidential medical information according to this Authorization:

CAMPER INFORMATION

Name _____ Date of birth _____ SSN _____
Street address _____ City _____ State _____
Zip _____ Phone number _____ Maiden/previous names _____
***I hereby give my permission to release any records necessary to the medical personnel or dental personnel selected by Camp Albrecht Acres of the Midwest.**

PURPOSE OF RELEASE

• Transferring medical care • Insurance coverage • Case coordination/referral • Legal purposes •

This authorization is effective for one year from the date on which it is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it. I understand I have the right to inspect the information to be disclosed upon the proper notification.

The **Releasee** does not require completion of this form as a condition of evaluation or treatment. However, if the evaluation or treatment is solely for the purpose of creating a medical report for a third party, those services are subject to cancellation if authorization to release the information to that party is not provided.

I understand that the person or entity that receives the information requested may not be covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with a covered person or entity and the medical information may no longer be protected by the regulations.

Electronic transmission of records (Faxing/E- mail) I authorize electronic transmission (fax/secure e-mail) of my medical records. If any portion of the fax/e-mail is received by an inappropriate third party in error, I release the Releasee, its physicians and staff of any and all liability relating to the disclosure of said records. Records may be provided in electronic form on a secure disk. Paper records are available upon request.
I understand that information to be released may include material that is protected by Federal and/or State law concerning mental health, substance abuse treatment, AIDS–related information and genetics unless I specifically deny the release by initialing the category below:

Please initial beside any category you do NOT want to be released. Substance abuse (drug or alcohol) _____
Genetics _____ Mental health information _____ AIDS–related information, diagnosis, & test results _____

I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidential information to the person or entity listed above. In order for the information to be released, you must sign below. If mental health information is being disclosed, I acknowledge receipt of a copy of this authorization.

Signature of camper or camper's legal representative_____ Date_____

Printed name and relationship of campers's legal representative_____
(Authority to act on behalf of patient requires attachment of such documentation)