

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Release TO: _____ Release FROM: _____

Address: _____ Address: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Specifically, I Request for The Following to Be Sent:

- Radiology Report(s) and Imaging
- Physician's Reports
- Complete Records

This authorization is indefinite until revoked. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that I may have a right to inspect disclosed information at any time and that such inspection will occur in a meeting with a member of the professional staff.

PROHIBITION ON REDISCLOSURE: This form does not authorize redisclosure of Medical Information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for substance abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa code Ch. 22) prohibits further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and or regulations. A general authorization for the release of Medical or other Information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of substance abuse or mental health information.

Signature of Patient or Patient's Authorized Representative

Date Signed

OFFICE USE ONLY

Sent Via: Fax Mail Sec. Email

Date Sent: _____ Staff Initials: _____