Authorization for Release of Confidential Health Information

Patient Name:_______________________________________ Date of Birth:_________________________

Social Security #:_________________________________ Phone #:________________________________

Release of Information **From**: Name:____

Address:____

City, State,Zip:____

Phone:_________________________Fax:___________________________

Release of Information **To**: Name:____

Address:____

City, State, Zip:____

Phone: _________________________ Fax:__________________________

I am requesting the information listed below for the following time period: from: _________to___________.

All Medical Records ***including*** mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/AIDS records

Information necessary to process FMLA and/or disability claims, including mental health or HIV/AIDS records

Specific:____

The purpose(s) of the authorization is (are)

FMLA or disability related

Shared medical care

Dissatisfied with Care

Transferring Care

Insurance Underwriting

Other______________________________

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation of refusal to sign this authorization will not affect my ability to obtain health care services. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from which disclosure is sought in writing.

I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be re disclosed and will no longer be protected by the regulations.

Iowa and/or Federal law provides that I have a right to prohibit re disclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below.

I further understand that the recipient, without further authorization, may re disclose said information to: Parties and their legal counsel, insurers, experts, potential experts, anyone against whom claim is or has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any said persons.

I understand this release is valid for 60 days from date of signature, unless revoked in writing by me.

____ _____________________________________

Signature of Patient or authorized representative Date

____ _____________________________________

Print Name Relationship to Patient

Information was: given to patient___________ mailed___________ faxed__________ other____________________