

**Patient Information:**

Name _____ Date of Birth _____ SSN _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____ Maiden/Previous names _____

Physician/Provider (records are being sent from): _____**Send records to (where you want records sent):**

Name: _____

Street Address: _____

City, State, Zip: _____

Phone # _____

Fax # _____

Specific records you want sent:

Dates: _____

 Complete records Lab data Operative report EKG History & Physical Radiology data Discharge Summary Other _____**Purpose of Release:** Transferring Medical Care Insurance Coverage Case Coordination/Referral Moving Legal Purposes At Request of Patient Other (please specify) _____**I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.**

Specific Authorization for Release of Information protected by State or Federal Law: This form does not authorization re-disclosure of medical information beyond the time limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42C.F.R. part 2) and state requirements (Iowa Code ch.228) prohibit 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 alcohol/drug abuse or mental health information.

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization 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.

Electronic transmission of records (Faxing/E-mail): I authorize electronic transmission (faxing/e-mail) of my medical records, if requested. If any portion of the fax/e-mail is received by an inappropriate third party in error, I absolve the physician listed above, their staff and The Iowa Clinic, PC of any and all liability relating to the submission of said records.

Patient or Legal Representative: _____ **Date:** _____**Relationship, if not patient:** _____**Please fax to: 515-875-9600 or mail to: Iowa Clinic Support Services, 6800 Lake Dr., Ste 270, West Des Moines, IA 50266******Please note: The Iowa Clinic charges a cost-based fee for the copying and releasing of medical records.**