THE IOWA CLINIC®

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO/FROM THE IOWA CLINIC

Patient Information

Patient Name _____ Date of Birth_____

Phone_____ Email _____

Street Address _____ City_____ State_____ Zip _____

Purpose Of Release

❑ Transfer ❑ Insurance ❑ Referral ❑ Moving ❑ Legal ❑ Per Patient Request ❑ Other _____

Please complete ONLY ONE BOX below

NEW PATIENT releasing information from:
(Releasing information from outside clinic or facility to The Iowa Clinic)

Clinic/Facility Name_____

Address _____

City _____

State _____ Zipcode _____

Phone _____ Fax _____

Email _____

Releasing information to The Iowa Clinic Support Services, see address below

EXISTING PATIENT releasing information to:
(Releasing information from The Iowa Clinic to outside entity)

Clinic/Facility/Name_____

Address _____

City _____

State _____ Zipcode _____

Phone _____ Fax _____

Email _____

Name Of Provider/Service Dates

_____ / _____

_____ / _____

Information To Be Released (Check All That Apply)

❑ Complete Medical Records ❑ Radiology Reports ❑ Radiology Images ❑ Other _____

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 ____ AIDS Related (Diagnosis & Test Results)

How Would You Like To Receive Your Records

❑ Mail ❑ Email ❑ Fax ❑ Patient Pickup (Pickup At 7147 Vista Drive, West Des Moines, IA)

I authorize electronic transmission (fax/secure e-mail) of my medical records. Records may be provided in electronic form on a secure disk. Paper records are available upon request. 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 Iowa Clinic 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.

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 Patient or Patient's Legal Representative _____ Date _____

Print Name and Relationship of Patient's Legal Representative _____

(Authority to act on behalf of patient requires attachment of such documentation.)

Please fax to 515.875.9600 or mail to The Iowa Clinic Support Services, 7147 Vista Drive, #170, West Des Moines, IA 50266
Please note: The Iowa Clinic charges a cost-based fee for the copying and releasing of medical records. Questions? Please call us at 515.875.9350.