AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: ____ DOB: ________________________

ADDRESS: ____

CITY/STATE/ZIP CODE: ____

PATIENT'S PHONE #: (   ) ____

DATE OF REQUEST:______________________________ DATE NEEDED: ____________________________________

OR

☐ I authorize Cedar Rapids OB-GYN Specialists, P.C. **to release information to**:

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone # Fax #

☐ I authorize Cedar Rapids OB-GYN Specialists, P.C., **to obtain information from**:

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone # Fax #

PURPOSE FOR THIS REQUEST:

☐ Continuing medical care ☐ Insurance coverage ☐ Second Opinion ☐ Other _________________ ☐ Transfer of care

INFORMATION TO BE DISCLOSED:

☐ Complete health record
☐ History and Physical exam
☐ Consultation report
☐ X-ray reports
☐ Medication list
☐ Laboratory reports
☐ Discharge summary
☐ Progress note
☐ Photo, video, or other images
☐ Other: ________________________

REASON FOR TRANFER OF CARE:

____

____

____

AUTHORIZATION VALID FOR: (Check one.)

☐ This request only.
☐ One year from the date of this authorization.
☐ This request **and** for medical records of any **future** treatment of the type described above until: ________________

I understand that:

- I may revoke this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I understand that I may inspect or copy any information used/disclosed with the authorization.
- I understand that if the person or entity that received the information is not a health care provider or health plan covered by federal privacy regulation, the information disclosed above may be re-disclosed and no longer protected by this regulation.

SPECIFY AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE/FEDERAL LAW:

I specifically authorize the release of information related to (you must answer yes or no):

☐ Yes ☐ No Substance abuse (Alcohol/drugs)
☐ Yes ☐ No Mental health (Psychologist testing, Behavioral health services)
☐ Yes ☐ No HIV related information (AIDS)

Printed Name: ____ Date _________________

Signature: ____

Witness: ____

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