THE IOWA CLINIC

Authorization for Release of Information from The Iowa Clinic, P.C.

I, as the patient or patient's legal representative, authorize The Iowa Clinic, P.C. or affiliate of The Iowa Clinic to disclose, release and deliver confidential medical information according to this Authorization:

Patient Information:

Name:_____ Date of Birth: _____ SSN: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____ Maiden/Previous Names: _____

The Iowa Clinic Physician/Provider (records are being sent from): _____

Send records to (where you want records sent):	**Specific records you want sent:**
Name: _____	Dates: _____
Street Address: _____	__ Complete records __ Lab data
City, State, Zip: _____	__ Operative report __ EKG
Phone #: _____	__ History & Physical __ Radiology data
Fax #: _____	__ Discharge Summary
	__ Other _____

Purpose of Release: ___ Transferring Medical Care ___ Insurance Coverage ___ Case Coordination/Referral ___ Moving ___ Legal Purposes ___ At Request of Patient ___ Other (please specify) _____

This authorization is effective for one year from the date on which it is 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.

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 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 a covered person or entity, the medical information may be redisclosed and will no longer be protected by the regulations.

Electronic transmission of records (Faxing/E-mail): I authorize electronic transmission (fax/secure e-mail) of my medical records. If any portion of the fax/e-mail is received by an inappropriate third party in error, I release The Iowa Clinic, its physicians and staff of any and all liability relating to the submission of said records.

Records may be provided in electronic form on a secure disk. Paper records are available upon request.

Patient or Legal Representative: _____ **Date:** _____

Relationship, if not patient: _____

Please fax to: 515-875-9600 or mail to: The 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.

Specific Authorization for Release of Information protected by State or Federal Law concerning Mental Health, Substance Abuse Treatment or AIDS-Related Information.

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable boxes:]

_____ **Substance Abuse (Drug or Alcohol) Information from:**

_____

_____

(Name of agencies, facilities, or individuals)

_____ **Mental Health Information from:**

NOTE: You have the right to inspect the disclosed mental health information at any time.

_____

_____

(Name of agencies, facilities, or individuals)

_____ **AIDS-related Information, Diagnosis, and test results from:**

_____

_____

(Name of agencies, facilities, or individuals)

Furthermore, 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 here. 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

_____

Printed name and relationship of patient's legal representative

Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information be accompanied by the following statement:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
>
> See also Chapter 228 and Chapter 141(A) of the Iowa Code and other applicable laws.