



## 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 \_\_\_\_\_  
Phone number \_\_\_\_\_ Maiden/previous names \_\_\_\_\_

Please provide the name of physician/provider or the specialty which records are needed from \_\_\_\_\_

☐ Send to address above ☐ Send records to the below

Specific records you want sent with service dates \_\_\_\_\_

Name \_\_\_\_\_

☐ Billing records ☐ Operative report ☐ Lab data

Street address \_\_\_\_\_

☐ Discharge summary ☐ EKG ☐ Radiology reports

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

☐ History & physical ☐ Radiology films & images

Phone \_\_\_\_\_ Fax \_\_\_\_\_

☐ Complete record ☐ Other \_\_\_\_\_

Email \_\_\_\_\_

### PURPOSE OF RELEASE

☐ Transferring medical care ☐ Insurance coverage ☐ Case coordination/referral ☐ Moving ☐ Legal purposes

☐ Request by patient ☐ Other \_\_\_\_\_

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.

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

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 information \_\_\_\_\_ AIDS-related information, diagnosis, & test results \_\_\_\_\_

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 \_\_\_\_\_

Printed 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, 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.**  
**If you have any questions please call us at 515-875-9350.**