Clarinda Regional Health Center

REQUEST FOR AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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Clarinda, IA 51632
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PATIENT INFORMATION:

Patient Name: _____ DOB:_____
Address: _____ Phone:_____
City: _____ State:_____ Zip:_____

RELEASE INFORMATION FROM:

Person and/or Place: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax:_____

RELEASE INFORMATION TO:

Person and/or Place:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

PURPOSE FOR RELASE OF RECORDS:

___Continuing Care ___Changing Physician
___Moving ___Personal
___Discharge Summary ___Insurance
___Military ___School

INFORMATION TO BE RELEASED:

___All ___Doctor's notes
___Labs ___X-rays (reports and/or films)
___EKG's ___Operative Report ___ER
___H&P ___Discharge Summary
___Other:_____

DATES OF SERVICE:

_____ to _____ or ___All

THE FOLLOWING PERSON HAS PERMISSION TO PICK UP MY MEDICAL RECORDS

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____Do **NOT** release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) If this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. **This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here:**_____

ID verification: ___Photo ___Other_____ Verified by: _____

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Relationship to Patient Completed by / Date

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