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	Laboratory reports
History and Physical exam	Discharge summary
Consultation report	Progress note
X-ray reports	Photo, video, or other images
Medication list	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: _____

Cedar Rapids OB-Gyn Specialists, P.C.
788 8th Avenue SE, Suite 100 Cedar Rapids, Iowa 52401
Phone: 319-363-2682, Fax: 319-363-1473