cedar rapids OB-GYN specialists

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

PATIENT'S PHONE #: ( ) _____

DATE OF REQUEST: _____ DATE NEEDED: _____

☐ 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 #

OR

☐ 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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