



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ DOB: _____
 ADDRESS: _____
 CITY/STATE/ZIP CODE: _____
 PATIENT'S PHONE #: () _____
 DATE OF REQUEST: _____ DATE NEEDED: _____

<input type="checkbox"/> 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 # _____	<div style="border: 1px solid black; padding: 2px; width: 40px; margin: 0 auto;">OK</div> <input type="checkbox"/> 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 # _____
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PURPOSE FOR THIS REQUEST:
 Continuing medical care Insurance coverage Second Opinion Other _____ Transfer of care

INFORMATION TO BE DISCLOSED: <input type="checkbox"/> Complete health record <input type="checkbox"/> Laboratory reports <input type="checkbox"/> History and Physical exam <input type="checkbox"/> Discharge summary <input type="checkbox"/> Consultation report <input type="checkbox"/> Progress note <input type="checkbox"/> X-ray reports <input type="checkbox"/> Photo, video, or other images <input type="checkbox"/> Medication list <input type="checkbox"/> Other: _____	REASON FOR TRANSFER OF CARE: _____ _____ _____
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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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