220 Essie Davison Dr. P.O. Box 217 Clarinda, IA 51632
Phone: (712) 542-8302 Fax: (712) 542-8346

REQUEST FOR AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: ________________________________ DOB: ______________
Address: ____________________________________ Phone: _____________
City: ___________________________ State: _____ Zip: ________________

RELEASE RECORDS FROM

Person and/or Place: ____
Address: ____
City: __________________________________ State: _____ Zip: ______________
Phone: _________________________ Fax: _________________________

RELEASE RECORDS TO

Person and/or Place: ____
Address: ____
City: __________________________________ State: ______ Zip: ______________
Phone: _________________________ Fax: __________________________

PURPOSE FOR RELEASE OF RECORDS:

___ Continuing Care ___ Changing Physician ___ Moving ___ Personal
___ Legal/lawyers ___ Insurance ___ Military ___ School

INFORMATION TO BE RELEASED

___ All ___ Doctor's notes ___ Labs ___ X-rays (reports and/or films) ___ EKG's ___ H&P
___ Discharge Summary ___ Operative Report __ ER ___ Other___________________

DATES OF SERVICE:

_____________ to _____________ OR ___ All past, present, and future visits

THE FOLLOWING PERSON HAS PERMISSION TO PICK UP MY MEDICAL RECORDS

NAME: ______________________________ RELATIONSHIP: _______________
NAME: ______________________________ RELATIONSHIP: _______________

State/federal laws require specific authorization to release the following types of information:
____ Mental Health ___ HIV/AIDS test results ___ Alcohol/Drug Abuse

By signing this authorization form I understand that:

- *It may take a minimum of 24 to 48 hours to obtain requested Clarinda Regional Health Center information*
- *Requests for copies of medical records are subject to reproduction fees with accordance with federal/state regulations.*
- *I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at above address. Revocation will not apply to information that has already been disclosed in response to this authorization*
- *Unless otherwise revoked this authorization will expire on _______________ or one year from date signed.*
- *Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization*
- *Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.*

ID verification ___ Photo ___ Other _____________________ Verified by _________________

____________________________________ ___________________________
Patient or Authorized Representative Signature Date

____________________________________ ___________________________
Relationship to Patient Completed by /Date