

Clarinda Regional Health Center
823 S. 17th St, PO Box 217
Clarinda, IA 51632

Clarinda Medical Associates
218 W Division St, PO Box 217
Clarinda, IA 51632

Villisca Family Health Center
309 S 5th Ave.
Villisca, IA 50864

Page Home Health
822 S 17th St
Clarinda, IA 51632

AUTHORIZATION TO RELEASE INFORMATION

Name of Patient: _____ Date of Birth: _____

I, the undersigned, hereby authorize: _____
to release the following information pertaining to my health care to:

Name and address of facility to receive information

All information or only the following (specify dates of service):

RELEASE TO FRIEND OR FAMILY MEMBER: I am authorizing the release of my medical information to the following person(s) for _____ day(s) or a period of time, which is: _____ . Please identify the relationship to you, such as Mother, spouse, child, etc.

Authorized Person _____ Relationship _____

I understand that the information being disclosed according to this authorization may be subject to re-disclosure by the recipient of this information; your information will no longer be protected by the privacy rule (45 C.F.R. 164.508, App. V.)

I understand that this authorization is good for _____ months, but no longer than 12 months from the date signed. I understand that this consent may be revoked in writing at any time and that any release made prior to my revocation and which was made in reliance upon this consent shall not constitute a breach of my rights on confidentiality. I understand that this facility, all employees/officers, and attending physician is released from legal responsibility or liability for release of above information to the extent indicated and authorized herein.

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|----------------------------------|------------------|-------------|--------------|
| _____ Date | _____ Name | | |
| _____ Address | _____ City | _____ ST | _____ Zip |
| _____ Relationship to patient | _____ Witness | | |