



## **Authorization/Request for Release of Medical Information**

Instructions	Make sure all blanks are filled in. Failure to do so could prevent or delay processing		
	Name (Legal/Maiden/Other)		
PATIENT INFORMATION	Address:		
	City: State: Zip:		
RELEASING ENTITY	Phone: Date of Birth:		
(Who is authorized to release the information)	Provider Name:		
the information,	Address:		
	City: State: Zip		
	Phone: Fax		
RECEIVING ENTITY: (Where do you want the information sent)	Requestor Name:		
information sent)	Address:		
	City: State: Zip:		
	Phone: Fax:		
INFORMATION Service Dates:			
REQUESTED (Charge may apply)	☐ Pertinent records - Most recent office visits, hospital visits, Operative reports, and testing		
(charge may apply)	☐ Entire Record ☐ Laboratory ☐ Immunization Record		
	□ EKG/Cardiology Testing □ Radiology □ Discharge Summary		
	☐ History & Physical ☐ Other		
PURPOSE OF RELEASE	☐ Continued Care ☐ Insurance ☐ Legal		
(Check all that apply)	☐ Moving ☐ Personal ☐ Transferring Care		
	□ Other		
REQUESTED FORMAT	☐ Paper ☐ CD (Password Protected) ☐ Mailed		
	☐ Faxed to:		
	☐ Call at (phone #) Pick up		
	Date		
** SPECIFIC AUTHORIZATI	ON FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW*		
PLEASE CHECK EACH BOX YOU DO NOT AUTHORIZE  I specifically do not authorize the release of information which may include or relate to:			
☐ Substance Use/Abuse ☐ Mental Health ☐ STD /HIV-related information ☐ Genetic Information			
Signature of Patient or Legal Rep	presentative Relationship		

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(Rev. 6-13-18)	

Prohibition on Conditioning of Authorization: MercyOne Des Moir Clinics or MercyOne Iowa Heart Centers will not condition treatment, payr signing this authorization unless:  • You are receiving research-related treatment or  • The only reason the facility is providing you with health care is to employer(e.g., fitness to return to work) or school (e.g., athletic p	ment or enrollment/eligibility for benefits on make a report to a third party such as your
<b>EXPIRATION:</b> This authorization is effective for month which it was signed.	s but no longer than one year from the date on
<b>REVOCATION:</b> I understand I may revoke this authorization at any time, been taken in reliance upon it, by giving a written notice.	except to the extent that action has already
<b>INSPECTION:</b> I understand I have the right to inspect the information to and under appropriate conditions established by MercyOne Des Moines W or MercyOne Iowa Heart Centers.	· · ·
PLEASE BE AWARE THERE MAY BE A FEE ASSOCIATE  The statement made in this authorization are binding, controlling and over statements in the organization Notice of Privacy Practices.	·
Signature of Patient or Legal Representative	
Signature of Patient or Legal Representative  Relationship to Patient, if not signed by Patient:	Date:
	Date:
Relationship to Patient, if not signed by Patient:	ntiality rules (42 CFR part 2) and state requirements of information in this record that identifies a patient as available information, or through verification of such exwritten consent of the individual whose information is reference of medical or other information is NOT ation to investigate or prosecute with regard to a crime
Relationship to Patient, if not signed by Patient:  Witness  PROHIBITION OF REDISCLOSURE This information has been disclosed to you from records protected by federal confider (lowa Code, ch 228). The federal rules prohibit you from making any further disclosure having or having had a substance use disorder either directly, by reference to publicly identification by another person unless further disclosure is expressly permitted by the being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization fo sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information of the purpose (see § 2.31).	ntiality rules (42 CFR part 2) and state requirements of information in this record that identifies a patient as available information, or through verification of such written consent of the individual whose information is reference to medical or other information is NOT ation to investigate or prosecute with regard to a crime 5.

Fee Due: \_\_\_\_\_ Fee Paid: \_\_\_\_\_