PHYSICIANS' CLINIC
of Iowa, P.C.

MEDICAL RECORDS RELEASE FORM

Last Name _____ First Name _____ Middle Name _____

Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

I authorize the use or disclosure of the above named patient's health information as described below:

Release records from these PCI Specialties: *(check all that apply)*

- ☐ Allergy/Immunology
- ☐ Audiology/Hearing Aids
- ☐ Cardiothoracic Surgery
- ☐ Ear, Nose & Throat/Head & Neck
- ☐ General Surgery
- ☐ Hematology & Oncology
- ☐ Neurology & Sleep Medicine
- ☐ Orthopaedic Surgery
- ☐ Osteoporosis & Bone Health
- ☐ Physical & Occupational Therapy
- ☐ Plastic & Reconstructive Surgery
- ☐ Podiatric Medicine/Surgery
- ☐ Rheumatology
- ☐ Surgical Oncology
- ☐ Urology
- ☐ Vascular & Endovascular Surgery

RELEASE FROM:

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Fax _____

RELEASE TO:

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Fax _____

Release records for the purpose of: *(check all that apply)*

☐ Continued Care ☐ Insurance ☐ Legal ☐ Request of Patient ☐ Other (explain)_____

Information to be disclosed: *(check all that apply)*

☐ Office Notes ☐ Operative Reports ☐ Lab Results ☐ X-ray Reports *(indicate condition)* _____ ☐ with images*

☐ Abstract Summary* ☐ Other (explain)

Dates of service: _____

**** I understand that I may be required to pay all or part of the processing fee for the records/x-rays that are released. If payment is not received in advance, I may be billed by Physicians' Clinic of Iowa for this service.***

I understand that Physicians' Clinic of Iowa does not require this form as a condition of evaluation or treatment and that I have the right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Health Information Department. I understand that my revocation will not apply to information that has all ready been released in response to this authorization.

I also understand that I have a right to view and/or receive copies of my health information and that there may be a charge for copies. In support of your privacy, Physicians Clinic of Iowa does not accept your blanket authorization to disclose heath information of treatment not yet received unless the authorization specifically requests release of information of further treatment of the condition treated in the originally requested episode. A new authorization will be required for each new episode of care. I understand that if I refuse to authorize the disclosure of information, the information may not be released. Refer to the Notice of Privacy Practices for more information about your rights with your health information.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

If information of the following types are available, I give permission for its release: ***(you must check appropriate boxes)***

- ☐ Acquired immunodeficiency syndrome (AIDS) / human immunodeficiency virus (HIV) infection
- ☐ Behavioral health service/psychiatric care
- ☐ Treatment for alcohol and/or drug abuse

_____

SIGNATURE OF CLIENT OR LEGAL GUARDIAN DATE

You must sign in order for above information to be released.

I understand that the information in my health record may include information relating to mental health, substance abuse, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). I understand that if I refuse to authorize the disclosure of information, the information may not be released.

I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws. This authorization automatically expires 365 days from the date this authorization is signed by the patient below unless otherwise noted.

Signature of Patient/Legal Representative _____ Date _____

I herby authorize this person to pick up my records _____ Relationship _____

Mail to: Physicians' Clinic of Iowa, ATTN: Health Information Services, 202 10th Street SE, Cedar Rapids, IA 52403 OR Fax to: (319) 449-3892.
For questions, please call (319) 398-1596.