AUTHORIZATION FORM for Release of Information

Grand River Medical Group
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Dubuque, IA 52001
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ALL BOXED IN AREAS MUST BE COMPLETED

Please release the medical record (**limited to the most recent 3 years**, unless otherwise specified), including any information or records relating to mental health, substance abuse (alcohol or drug), and HIV/AIDS *unless* excluded below** for:

_____ born _____, residing at _____
(Patient's name) *(birth date)* *(Street address, City, State, Zip code)*

Complete this section only if you want to be more specific about the extent of the medical record released (check as many boxes as apply):

- ❑ All information in the medical record from: _____ to _____.
- ❑ Laboratory reports *(date)* *(date)*
- ❑ X-ray reports/films
- ❑ Operative reports
- ❑ Other (be specific) _____

** In addition, I do NOT want any of the following information released:

- ❑ Mental health treatment records
- ❑ Alcoholism treatment records
- ❑ Drug abuse treatment records
- ❑ HIV/Acquired immunodeficiency syndrome(AIDS) records

Please RELEASE the medical records outlined above FROM entity "A" TO entity "B" as designated below:

FROM
(A): _____
Please list name of health care facility/ physician FROM whom records are requested, address(including city, state and zip code, and phone / fax number, if known

TO
(B): _____
Please list name of health care facility/ physician TO whom records are requested, address(including city, state and zip code, and phone / fax number, if known

The purpose(s) of this authorization is (are):_____

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event that I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where my physician has already relied on it to use or disclose my health information. Written revocation must be sent to our office.
- This Authorization for Release of Information will be valid for 1 year but only for medical information that was available ON or BEFORE the date that this authorization was signed. A new, separate authorization will be required for release of protected health information after the date this authorization was signed.

Signed: _____ Date _____.

If you are not the patient, please specify your relationship to the patient: _____.

You may be charged a reasonable fee for copying of your records.

(Office use only)

Reviewed and approved by Dr. _____ Information sent by _____ Date sent _____ Service fee$_____