AUTHORIZATION FORM for Release of Information

Grand River Medical Group
1515 Delhi Street, Suite 100
Dubuque, IA 52001
Office: 563-557-3926
Fax: 563-557-5560
Email: grmgroi@gr-mg.com

I authorize Grand River Medical Group to release the full medical record of the below named patient, **limited to the most recent 3 years**, unless otherwise specified. **Complete all *required information, if incomplete, request will be denied.**

*Patient Name: _____ *Date of Birth: _____

*Patient Address: _____ _____ _____ _____ _____
Street address *City* *State* *Zip code* ** Phone number*

Per federal law all mental health, substance abuse, and/or HIV/AIDS related information is NOT released with the above general request.

These records will not be released unless you request them by checking the box(es) below.

- ❑ Mental Health Evaluation and Treatment
- ❑ HIV/AIDS Related Health Information
- ❑ Substance Abuse Related Health Information

Complete this section ONLY if you want to be more specific about the request for medical record release (check as many boxes as apply): ❑All information in the medical record from:_____to_____.
(date) *(date)*

- ❑ Laboratory reports
- ❑ X-ray reports/films
- ❑ Operative reports
- ❑ Other (be specific) _____

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

***FROM (Entity A):** _____
**Health care facility/ physician* ** Street Address* ** City* ** State* **Zip code*

** Phone Number*_____ **Fax Number* _____

***TO (Entity B):** _____
**Health care facility/ physician/self* **Street Address* ** City* ** State* **Zip code*

** Phone Number*_____ **Fax Number* _____ **Email address*_____

***Purpose for requesting information** ❑ Transfer ❑ Insurance ❑ Legal ❑ Personal ❑ Other_____

- I understand I have the right to inspect and copy the information to be disclosed upon proper notification.
- I understand that I may revoke this authorization in writing any time, except to the extent that action has already been taken in reliance upon.
- 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 this authorization is effective for one year from the date which is signed unless revoked in writing.

***How would you like to receive your records** ❑ Mail ❑ Email ❑ Fax

*Signature of patient or patient's legal representative: _____ *Date _____

*If you are not the patient: Print your name: _____

*Relationship to the patient: _____

You may be charged a reasonable fee for copying of the above requested medical records.

(Office use only)

Information sent by _____ Date sent _____ Service fee$___