AUTHORIZATION FORM
for Release of Information

Grand River Medical Group
1515 Delhi Street, Suite 100
Dubuque, IA 52001
Office: 563-557-9111
Fax: 563-589-4004

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 below:

Patient Name: ______________________________ Date of Birth: ____________________

Patient Address: ____
Street address *City* *State* *Zip code*

Per federal law all mental health, substance abuse, and/or HIV/AIDS related information is NOT released with the above general request. If you want this protected information included with the above request please check the box(es) below on what information should be included.

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*

*If known: Phone Number*______________________ *Fax Number* ______________________

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

*If known: Phone Number*______________________ *Fax Number* ______________________

- 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.
- 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.

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)

Reviewed and approved by Dr. _________ Information sent by ________ Date sent ________ Service fee$______