AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:	**Date of Birth:**
MRN #:	**Parent/Guardian:**

The above-named person must indicate when this authorization is to expire:

☐ When the information is received	☐ In one year
☐ In six months	☐ In three years
☐ On date:	

The person named above is or has been a patient of ________________________ and authorizes the following individuals or agency to:

☐ Request health information ☐ Discuss health information ☒ Send health information

FROM	**TO**
Name: Urology Center of Iowa	Name:
Address: 12129 University Ave.	Address:
City/State/Zip: Clive, IA 50325	City/State/Zip:
Phone: 515-400-3550 Fax: 515-400-3551	Phone: Fax:

Scope:

☒ All information regarding assessment, diagnosis, and treatment of the patient's condition, concern or disease (Specify):____.

☐ All information regarding care received by the patient (starting date):___________________ (ending date):_________________.

☐ Other information (specify): ____
____.

Authorization:

Printed name of patient:____.

Signature of patient or
Authorized Representative:__________________________________ Date:__________________.
Signature of witness:_______________________________________ Date:___________________.

If not signed by the patient, indicate the relationship of authorizing person to patient:

☐ Parent of guardian of minor child ☐ Guardian or conservator of the conserved patient

☐ Beneficiary or personal representative of a deceased individual.

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Certain information is covered by additional protection and requires specific authorization. To authorize the release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed or dated, the information, if such information exists, cannot be released, or discussed.		
Type of Information	**Initial**	**Date**
Alcohol or Drug Use/Abuse Treatment		
Mental Health Status		
HIV Status or Treatment		

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that it has been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our privacy practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient's such additional disclosures are releases that may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your healthcare provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits.

PLEASE NOTE: Unless otherwise specified by law, we will release only that information that has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other provided providers or facilities.

There might be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for your future releases to you, or releases to other providers, persons, or facilities may be subject to a reasonable charge. Please contact our clinic office manager or site administrator for additional information about applicable copying fees.