Authorization to Release Information

Patient Name (Printed)_____ **Date of Birth**____/____/_____
By signing this form, I authorize _____ to release medical information concerning the above named patient to the person or facility listed below. A copy of this information will be mailed to the facility listed below.

Affordable Healthcare P.C. 3343 Center Grove Drive, Suite H, Dubuque, IA 52003 _____X_____
Other:_____

Please specify the information to be released:
Medication List____ Allergy List____Immunization record_____ Medical History_____
History and Physical (specify dates)_____
Laboratory Results (specify dates) _____
X-Ray and Imaging Reports, specify dates:_____
Test results, specify type and dates:_____
Billing information, specify: _____
Weight Loss Program History:_____
ENTIRE MEDICAL RECORD_____
Other, specify:_____

I understand the information might be released electronically, and may include information in the following categories unless I specifically deny the release (INITIAL any category NOT to be released)
Substance Abuse_____ Mental Health_____HIV-related information_____

The requested disclosure of information is for the following purpose:
Insurance____ Second Opinion_____ Personal file_____ Legal_____ Leaving area_____
Other Medical care_____ Transferring medical care:_____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to: Affordable Healthcare P.C. Attention Medical Records, 3345 Center Grove Drive, Suite H, Dubuque, IA 52003. If this content is cancelled, I understand that information may have been released prior to the cancellation and that action would not be considered a breach of confidentiality. I also acknowledge that 1) recipients of this information may possibly re-release the information without the proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or as questions by contacting the Office Manager at Affordable Healthcare P.C. I understand there may be a fee associated with this.

Affordable Healthcare P.C. does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.
This authorization expires on ____/_____/_____, or if not specified, one year from the date signed. I understand that I may revoke this authorization at any time by a written request to do so.

Signed:_____ Date_____
Signature of Patient or Legal Guardian
Complete Mailing address: _____
Relationship, if not the patient:_____
Witness:_____ Date_____
Affordable Healthcare P.C. 3343 Center Grove Drive Suite H, Dubuque IA 52003
Phone: 563-582-1000 Fax: 563-582-1113