AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________ Date of Birth: ______________________________

Maiden/Other Name: ______________________________ SSN # (last 4 digits): ______________________________

Address: ______________________________ Phone #: ______________________________

City, State, Zip: ______________________________

I authorize the use or disclosure of the patient's medical records **as described below:**

I hereby authorize the release of my medical **records** from**:**

☐ **Floyd Valley Community Health**
714 Lincoln St NE
Le Mars, IA 51031
712-546-3335 phone
712-546-3451 fax

☐ **Floyd Valley Healthcare**
714 Lincoln St NE
Le Mars, IA 51031
712-546-7871 phone
712-546-3416 fax

☐ **Floyd Valley Clinics**
714 Lincoln St NE
Le Mars, IA 51031
712-546-8113 phone
712-546-9307 fax

☐ Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Fax: ______________________________

Information to be released:

☐ ANY and ALL records ☐ History & Physical
☐ Immunization records ☐ Hospital records ☐ Dates of Service: ______________to______________
☐ X-Ray reports ☐ Laboratory reports ☐ Other______________________________

Purpose of Disclosure:

☐ Transferring Care ☐ Continued Healthcare ☐ Moving ☐ Other______________________

Form and Format:

☐ Paper records ☐ Flash Drive ☐ Fax ☐ CD-ROM

☐ Email (All email transmissions will be sent encrypted.) If you choose to have your records sent via email, please provide the email address: ____.

Check this box ONLY if you DO NOT permit substance abuse records to be released. ☐ Requestor, take note: These released records contain substance abuse documentation, and therefore prohibition on redisclosure applies. THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISION OF FEDERAL STATUES (42 U.S.C. 290dd-2, and regulations 42 CFR, Part 2) which prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such allegations.

Health Information to be released to:

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☐ **Floyd Valley Clinics**
714 Lincoln St NE
Le Mars, IA 51031
712-546-8113 phone
712-546-9307 fax
Provider____________

☐ Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone: ______________________________
Fax: ______________________________

Unless otherwise revoked, this authorization will expire on the following date, event or condition: ___________. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed. I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Records Department. I understand the revocation will not apply to information already released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.

I understand authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information I can contact the Floyd Valley Healthcare Privacy Officer at 712-546-3397.

______________________________ ______________________________
Signature of Patient or Legal Representative Date

______________________________ ______________________________
If Signed by Legal Representative, Relationship to Patient Signature of Witness

In office use only.
Date information disclosed: ________
By whom: ______________________

HIPAA 1004.doc.consent.administration
Approved by Risk Management:
5/13/10, 2/12/13, 5/11/17, 12/14/17