SMC

Shenandoah Medical Center
300 Pershing Avenue
Shenandoah, IA 51601
712-246-1230

AUTHORIZATION FOR RELEASE OF INFORMATION

I Hereby authorize _____to release the following information from medical records of _____Date of Birth_____
To: _____
Address: _____
City: _____State: _____Zip_____
Purpose of Release:_____
From (Date) _____**To (Date)** _____

_____ Discharge Summary _____ History & Physical _____ Operative Reports
_____ Pathology Report _____Laboratory Results _____ X-Ray Reports
_____EKG/EEG Reports _____Emergency Room Reports _____Prenatal Records
_____Outpatient Clinic Notes _____Psychiatric Information _____Therapy Notes
_____Other (Please Specify) _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information.

I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO:

Put "Yes" or "No" next to all spaces provided

_____ Substance Abuse (Drug or Alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ Mental Health Information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ HIV or AIDS related information, diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

This statement of consent can be revoked at any time before disclosure of information, and expires, in any event, six months after it is signed. Date of expiration: _____/_____/_____
I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation. If authorizing disclosure of mental health records, I understand that I have the right to inspect the information to be disclosed upon proper notification and under appropriate conditions established by the releasing health care provider. I understand that individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

I AUTHORIZE DISCLOSURE OF THIS CONFIDENTIAL INFORMATION TO THE PERSONS/ENTITY/ADDRESS LISTED ABOVE

Signature _____ **Date** _____
Patient

_____ **Date** _____
Legal Guardian or Next of Kin