



PATIENT AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

1. I authorize _____ to release information from the health records of: _____

(Patient)

Account #: _____ Date of Birth: _____

2. The information is to be released to: _____

Recipient Address: _____

City, State, Zip: _____

Contact Person: _____

Phone/Fax: _____

I authorize this information to be disclosed in the following ways:

- Written/Photocopy/Paper Electronic Mail Fax

Reason for Release: _____

3. Dates of Treatment: From: _____ To: _____

Specific reports to be disclosed:

- Progress Notes Laboratory Reports Operative Reports
Discharge Summary Radiology Reports/Imaging Consultation Reports
Immunizations Records from Other Facilities
Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
Other (Specify): _____

I give specific authorization to disclose the following information:

- HIV test results Documentation of AIDS diagnosis
Drug and alcohol abuse treatment records Psychiatric/Mental Health treatment records*

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Shenandoah Medical Center in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Iowa privacy regulations.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Signature of Patient (or Patient Representative)

Date

Printed Name of Patient or Patient Representative

Authority of Representative to Act for Patient (Relationship to Patient)

*Release of Psychotherapy notes requires a separate authorization.