Fax: 515-225-0971

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient (print):____ Date of Birth: _______________________

SS No: ___________________________ Phone (home):__________________________ (work) _________________

Address: __________________________________City: ___________________________State: ______ Zip: ______________

I, the undersigned, authorize and request Iowa Sleep to:

- □ Release to
- □ Obtain from

Person/organization: ____

Address: ____

City: ____ State: _______________ Zip: _____________

Phone: _____________________________________ FAX: __________________________________

The following information from my medical records for care/treatment that I received from:

□ Any/all or as much information as the releasing healthcare provider, in its sole discretion, deems reasonably necessary for the purposes set forth by me for release.

□ Specific exclusions: ____

Purpose for disclosure: Treatment in Office________

This authorization is effective for no longer than 1 year from the date on which it is signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Privacy Officer. A photocopy or facsimile of this release shall have the same effect as an original. I understand I have the right to inspect the information to be disclosed, and include my written statement about the record, upon proper notification to and under appropriate conditions established by Iowa Sleep.
I acknowledge that the information to be released may include material that is protected by State and Federal Law applicable to other mental health, and/or drug and/or alcohol abuse and/or HIV/AIDS, and my signature authorizes release of such information, unless exceptions have been stated above. ___________________ (Initials)

PROHIBITION FOR DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by Federal and/or State Law. The authorization for release of information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, and State Law (Iowa Code ch 225 and 141) for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such laws and/or regulations. A general authorization for Release of Medical Information is NOT sufficient for these purposes. Civil and criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/AIDS information.

Signature of patient or representative____Date:_____________________________

Relationship to patient____

Witness____Date:____________________________

(A copy of this signed form must accompany released information.) Release processed (initials) _______Date_______________