



Fax: 515-225-0971

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient (print): _____ Date of Birth: ____/____/____

S.S. No: _____ Phone (home): _____ (work) _____

Address: _____ 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 Chief Compliance Officer Steven Zorn, M.D. 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 Steven Zorn, M.D.

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 _____