

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: _____

Please fax to 515-225-0971 or mail to Iowa Sleep Disorders Center, 4060 Westown Parkway, West Des Moines, IA. 50266
Please Note: Iowa Sleep Disorders Center charges a cost-based fee for the copying and releasing of medical records. Questions?
Please call us at 515-225-0188.