Iowa Family Practice

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I request the _____ to release medical records for:

Patient Date of Birth Medical Record #

To the following:
Name:_____

Address:_____

For the purpose of
[ ] Continuity of Care
[ ] Other: _____

This request and authorization applies to:
[ ] All healthcare information
[ ] Specific dates of service as indicated:_____

By INITIALLING, I specifically authorize the release of the following confidential information:
___ HIV test, test results and related information including high-risk behavior information
___ Drug/Alcohol diagnosis, treatment, or referral information
___ Mental Health treatment information
___ Other (specify):_____
This authorization is valid for 90 days from the date of signature unless cancelled by written notice by the patient/legal guardian.

_____ _____

Signature of patient or legal guardian Relationship to patient

_____ _____

Witness Date

Office use only

HAS THE HEALTHCARE INFORMATION BEEN RELEASED? _____ NO _____YES

SIGNATURE OF STAFF RELEASING INFORMATION:_____