Patient Authorization for Release of Medical Records

Please PRINT AND complete ALL sections below!

THE PATIENT DESCRIBED BELOW :

Sex: ☐ Male ☐ Female

Name: ______________________ (last name) ______________________ (first name) ________ (initial)

Date of Birth: ______ / ______ / ______ Social Security #: ______ - ______ - ______

Home Phone: (_____) __________________ Work Phone: (_____) __________________ Cell Phone: (_____) __________________

Address: ____________________________ Apt. #: _____ City: ______________ State: ____ Zip: __________

AUTHORIZES IOWA DERMATOLOGY INC. TO RELEASE PERSONAL HEALTH DATA TO :

Name: ____

Office Name: ____ Email: ______________

Address: ____________________________ Suite #: _____ City: ______________ State: ____ Zip: __________

Office Phone: (_____) __________________ Fax: (_____) __________________ Alt Phone: (_____) __________________

MEDICAL INFORMATION REQUESTED :

- ○ Complete Records
- ○ Progress Notes
- ○ Pathology Reports
- ○ Laboratory Reports
- ○ Dermatologic Photographs (incurs additional fee of $2.50 per photo)
- ○ Other: ____________________
- ○ Format:
  - ○ Electronic Copy (CCD / CD / PDF)
  - ○ Fax
  - ○ Hard Copy

REASON FOR RELEASE :

- ○ To update my regular family physician
- ○ Referral to another physician for continued care
- ○ I would like a second opinion
- ○ I am changing medical providers because of:
  - ○ Dissatisfied with services provided
  - ○ Insurance coverage
  - ○ Moving out of the area
  - ○ Other (please describe below)

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW: (REQUIRES RESPONSE)

I specifically authorize the release of data and information relating to:

Yes	No	
❑	❑	1. Substance Abuse (alcohol/drug abuse)
❑	❑	2. Mental Health/Depression (includes psychological testing)
❑	❑	3. HIV-Related Information (AIDS related testing)

This authorization will automatically expire one year from date of signature or until ______________, 201_____. This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS:
This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

AUTHORIZATION AND FINANCIAL AGREEMENT

I herby give authorization for Iowa Dermatology, Inc. to release confidential medical information as detailed above. Additionally, I understand that a fee will be assessed to the requesting party for the reproduction and transmission of data consistent with Iowa State Law. The fees assessed will be calculated based on the Iowa Medicaid fee schedule. Reproduction and transmission of photos will incur an additional cost of $2.50 per photo. I understand that I am financially responsible for all charges. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all non-medical information necessary to secure the payment for these services. I further agree that a photocopy or scanned image of this agreement shall be as valid as the original.

Patient (or agent) Signature:____ Date: ______________

Printed Name of Patient (or agent):____

If patient under 18 years of age, agents relationship to patient: ☐ Parent ☐ POA ☐ Spouse (with auth.) ☐ Other: ______________

Office Use Only

Request processed by ________________________ on ________/_______/201_____. Invoice created: ☐

Format: CCD ☐ / CD ☐ / PDF ☐ / Print ☐ Transmitted via: EF ☐ / Fax ☐ / US Mail ☐ / Email ☐ / Portal ☐