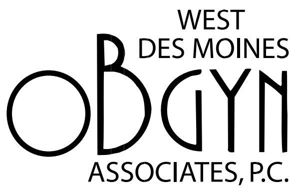

Authorization for Release of Protected Health Information (PHI)

PATIENT LAST NAME: ______________________ PATIENT FIRST NAME___________________

PATIENT DATE OF BIRTH ___________________ SSN #: ________________________________

TELEPHONE NUMBER (   ) __________________________

I hereby request **West Des Moines OB/GYN Associates** release/disclose my protected health information to:

Name: ____

Relationship to Pt__☐ Self_________☐ Other-________________________

Address: ____

City, State, Zip Code ____

Phone: (____)______________________ FAX: (___)__________________

*** Delivery Options:**

☐ Email ____________________________________ ☐ Fax (_____)________________

☐ PDF on CD ☐ PDF on FlashDrive ☐ Print to Paper ($11.00 fee) ☐ Other:______________________

*** The information released shall include (check that which applies):**

______ My last 5 years medical record ______ My entire medical record

______ Portions of my medical records pertaining to:_____________________________________

______ A specific date of service or test result:____

Other:____

Reason for release: (not required, for documentation purpose only)

______ Further specialty medical care ______ Personal use _______ Moving out of area ______ Transferring to a new provider ______ Other

Additional Release: I agree to the release of information regarding the following:

*HIV/Hepatitis status ______ ___ *Drug/Alcohol Abuse ______ ___ *Mental Health ______ ___
Initials Date Initials Date Initials Date

No information regarding these areas of care will be included in the records released unless specific authorization is provided. These areas are protected under the Federal regulations governing Confidentiality and Substance Use Disorder, 42 CFR Part-2, and the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without written consent.

Time Limit & Right to Revoke: Except in the event that action has already been taken, I can at any time revoke this authorization by submitting notice in writing to the address below. Unless revoked, this authorization will expire on the following date________________ or one year from date of signature, unless otherwise specified.

I understand that (1) my records are protected under Federal Health Insurance Portability and Accountability Act (HIPAA) law, as well as State of Iowa laws, (2) under HIPAA law, I have the right to review and request amendments to my records, where appropriate, (3) this authorization is applicable only for services provided on or before the date of this authorization, *unless* specifically stated otherwise in this authorization, (4) there is a copying fee of $11.00 only if records requested to be printed on paper. Payment must be received prior to the release of records.

PATIENT SIGNATURE: ____ DATE: _________________________

SIGNATURE OF LEGAL GUARDIAN (if applicable) ____

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