WEST DES MOINES OBGYN ASSOCIATES, P.C.

Authorization for Release of Protected Health Information (PHI) To West Des Moines OB/GYN Associates

PATIENT LAST NAME: _____ PATIENT FIRST NAME_____

PATIENT DATE OF BIRTH _____ SSN #: _____

TELEPHONE NUMBER ( )_____

I hereby request that the following health care provider or entity release/disclose my protected health information to **West Des Moines OB/GYN Associates**, located at 4949 Westown Parkway, Suite 140, West Des Moines, IA 50266-6716 **PLEASE FAX to 515-223-5405**

Name: _____

Address: _____

City, State, Zip Code _____

Phone: (___) _____ FAX: (___) _____

*** 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) _____