AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Maiden/Other Name: _____ SSN # (last 4 digits): _____

Address: _____ Phone #: _____

City, State, Zip: _____

I authorize the use or disclosure of the patient's medical records **as described below:**

I hereby authorize the release of my medical **records** from**:**

☐ **Floyd Valley Community Health**
714 Lincoln St NE
Le Mars, IA 51031
712-546-3335 phone
712-546-3451 fax

☐ **Floyd Valley Healthcare**
714 Lincoln St NE
Le Mars, IA 51031
712-546-7871 phone
712-546-3416 fax

☐ **Floyd Valley Clinics**
714 Lincoln St NE
Le Mars, IA 51031
712-546-8113 phone
712-546-9307 fax

☐ Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Information to be released:

☐ ANY and ALL records
☐ Immunization records
☐ X-Ray reports
☐ History & Physical
☐ Hospital records
☐ Laboratory reports
☐ Dates of Service: _____to_____
☐ Other_____

Purpose of Disclosure:

☐ Transferring Care ☐ Continued Healthcare ☐ Moving ☐ Other_____

Form and Format:

☐ Paper records ☐ Flash Drive ☐ Fax ☐ CD-ROM

☐ Email (All email transmissions will be sent encrypted.) If you choose to have your records sent via email, please provide the email address: _____.

Check this box ONLY if you DO NOT permit substance abuse records to be released. ☐ Requestor, take note: These released records contain substance abuse documentation, and therefore prohibition on redisclosure applies. THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISION OF FEDERAL STATUES (42 U.S.C. 290dd-2, and regulations 42 CFR, Part 2) which prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Health Information to be released to**:**

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Le Mars, IA 51031
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☐ **Floyd Valley Healthcare**
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Le Mars, IA 51031
712-546-7871 phone
712-546-3416 fax

☐ **Floyd Valley Clinics**
714 Lincoln St NE
Le Mars, IA 51031
712-546-8113 phone
712-546-9307 fax
Provider_____

☐ Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed. I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Records Department. I understand the revocation will not apply to information already released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.

I understand authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information I can contact the Floyd Valley Healthcare Privacy Officer at 712-546-3397.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Floyd Valley Healthcare

ROI

In office use only.
Date information disclosed: _____
By whom: _____

HIPAA 1004.doc.consent.administration
Approved by Risk Management:
5/13/10, 2/12/13, 5/11/17, 12/14/17