

**FAMILY MEDICAL CENTER, P.C.
PATIENT CONSENT FOR RELEASE OF INFORMATION**

Patient Name _____ Date of Birth _____ Social Security # _____

Street Address _____ City _____ State _____ Zip Code _____

Maiden or Previous Name(s) _____

I hereby authorize and request my Medical Record be released:

Note: If you are having someone pick up your medical records for you, put their name below

(TO/FROM)	(TO/FROM)
Family Medical Center, P.C. 410 North 12th, Suite 300 Oskaloosa, Iowa 52577 Phone: 641-672-2571 Fax: 641-672-2258	_____ _____ _____

List *Specific* Health Information to be released. Include date(s) of service, labs, x-rays, medications, etc.:

<u>Date of Service</u>	<u>Type of Service to be Released</u>
_____	_____
_____	_____

REASON FOR RELEASE: _____

I hereby authorize records from other entities/physicians be redisclosed to the above named recipient. _____
(Please initial)

I hereby authorize and request my health information be released to the named individual or company. I understand that this release is valid for a period of one (1) year from this date and that I may, at any time, revoke this request. I understand that I may be asked to present identification in order to claim my medical records.

_____	_____	_____
Signature of patient/guardian/legal representative	Relationship if not the patient	Date

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING PROTECTED INFORMATION:

_____ HIV/AIDS related service _____ Mental Health information _____ Substance abuse (alcohol/drug) _____ Genetic testing

I understand that this information may include material that is protected by Federal and State of Iowa Code. This portion of the release is valid for (1) time.

_____	_____	_____
Signature of patient/guardian/legal representative	Relationship if not the patient	Date

FOR OFFICE USE ONLY

RELEASE/DENIED BY _____ DATE _____ REASON FOR DENIAL: SEE ATTACHED SHEET

CHARGE FOR COPIES? YES / NO IF SO \$ _____ RECORD COPIED BY: _____ DATE _____