Physicians Office Building • Suite F • 804 Kenyon Road • Fort Dodge, Iowa 50501
Telephone: 515-576-3100 • 1-800-360-4442 • Fax: 515-576-3104 • web site: www.iowaent.com

# CONSENT TO RELEASE OF INFORMATION

Name ____________________________________________ Birthdate ____________________

Guardian, if minor ____________________________________________________________

I, the undersigned, hereby authorize ______________________________ to release medical information concerning the above named patient to:

______________________________________________________________________________
Name of Persons or Institutions

______________________________________________________________________________
Address City State Zip

This medical information will contain copies of discharge summary letters or clinical notes pertaining to the patient's evaluation and treatment. If additional information is necessary, please specify. All x-rays or hospital reports need to be obtained through that institution.

______________________________________________________________________________

This authorization will automatically expire one year from the date of signature, except as specified ____________________

______________________ (specific number of days or months).

At that time, no express revocation shall be needed to determine my consent, but I understand that I may revoke this consent at any time by sending a written notice to the Director of Medical Records, ______________________________

______________________________________________________________________________

I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the Director of Medical Records, ______________________________________________

* ____________________________________________________________
Signature of Patient or Legal Guardian Date

______________________________________________________________
Address City State Zip

______________________________________________________________
Relationship, if Not the Patient Witness

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW**

I specifically authorize the release of data and information relating to: (check the appropriate box)

❒ 1). Substance Abuse (alcohol/drug abuse)
❒ 2). Mental Health (includes psychological testing)
❒ 3). HIV-Related Information (AIDS related testing)

* ____________________________________________________________
Signature of Patient or Legal Guardian Date

*In order for the above information to be released, you must sign here and above and check the appropriate box(es).

Clinic Use Only

Information Sent ______________________
Date

By ______________________________
Name Department