AUTHORIZATION FOR RELEASE OF INFORMATION
TO OB GYN ASSOCIATES

Please Print

Patient's Full Name: _____
First Middle Initial Last

Street Address: _____ Birthdate: _____

City, State, Zip: _____ Soc. Security # _____ Phone: _____

I HEREBY AUTHORIZE:

(Where do you want it sent from?)

Doctor/Hospital: _____

Address: _____

_____

Fax:_____ Phone: _____

TO DISCLOSE AND DELIVER TO:

Doctor/Hospital: OB GYN Associates of Iowa City & Coralville, P.C.

Address: 2769 Heartland Drive #201 Coralville, IA 52241

Fax: 319.545.4570 Phone: 319.337.3193

CHECK THE INFORMATION TO BE DISCLOSED:

_____ Last Routine Physical
_____ Last 1 year of Medical Records
_____ Last 3 years of Medical Records
_____ Laboratory Results (specify type or date _____)
_____ X-Ray and Imaging Reports (specify type or date _____)
_____ Other, specify: _____

PLEASE INDICATE THE REASON FOR RELEASE:

_____ 2ND Opinion _____ Personal File _____ Moving out of area
_____ Transferring Care _____ Other _____

I ACKNOWLEDGE THAT INFORMATION TO BE RELEASED MAY INCLUDE MATERIAL THAT IS PROTECTED BY FEDERAL AND/OR STATE LAW APPLICABLE TO SUBSTANCE ABUSE, MENTAL HEALTH AND/OR AIDS RELATED INFORMATION. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION IN THE FOLLOWING CATEGORIES UNLESS I SPECIFICALLY DENY RELEASE.
(INITIAL ANY CATEGORY NOT TO BE RELEASED)

_____ Substance Abuse _____ Mental Health Information _____ AIDS Related Information

I understand that this authorization will automatically expire one year from the date of my signature. I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. OB GYN Associates will not refuse or restrict my treatment if I choose not to sign this authorization. Further, I realize that OB GYN Associates cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, OB GYN Associates is released from any and all liability resulting from redisclosure.

I authorize the release of information as indicated above and understand that I may review the disclosed information or ask questions by contacting the Practice Administrator of OB GYN Associates.

_____ _____
Patient/Guardian Signature Date