2769 Heartland Drive Suite201, Coralville, IA 52241

Phone: 319-337-3193

Fax: 319-545-4570

OB GYN ASSOCIATES
OF IOWA CITY & CORALVILLE, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name: _____ Date of Birth: _____

Address: _____ Phone: _____

☐ I authorize OB GYN Associates of Iowa City & Coralville, P.C. to **release** information to:	OR ☐ I authorize OB GYN Associates of Iowa City & Coralville, P.C. to **obtain** information from:
Provider/Facility: _____	Provider/Facility: _____
Address: _____	Address: _____
Phone: Fax:	Phone: Fax:

PLEASE INDICATE THE REASON FOR RELEASE:

☐ Continuing Medical Care ☐ Second Opinion ☐ Personal File ☐ Transferring Care

If you are **transferring care please provide suggestions regarding the care/communication from our clinic. We strive to uphold the highest standard of care.*

Suggestions: _____

INFORMATION TO BE DISCLOSED:

☐ Complete Health Record ☐ Lab Results ☐ X-ray Reports ☐ History and Physical Exam

☐ Other (please be specific): _____

AUTHORIZATION VALID FOR: (Check one)

☐ This request only.

☐ One year from the date of this authorization.

I understand that:

- ***I may revoke this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.***
- ***I understand that I may inspect or copy any information used/disclosed with the authorization.***
- ***I understand that if the person/entity that received the information is not a health care provider/health plan covered by federal privacy regulation, the information disclosed above may be re-disclosed and no longer protected by this regulation.***
- ***I authorize the release of information as indicated below and understand that I may review the disclosed information/ask question by contacting the Practice Administrator of OB GYN Associates.***

SPECIFY AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE/FEDERAL LAW:

Please select YES if you want us to RELEASE the information below.

Substance Abuse (Alcohol/Drugs)	Mental Health (Behavioral/Psychologist services)	HIV/AIDS Information
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

OB GYN Email: medicalrecords@obgyniowacity.com **Fax Number: 319-545-4570** **Phone Number: 319-337-3193**

Revised 11/2022