

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date: _____ Date of Birth: _____ SSN: _____

Patient Name: _____

Address: _____

I, the undersigned, do hereby grant permission for **Cardiologists LC** to obtain from or release to:

(Name of person or institution the information will be coming from)

(Address of person or institution the information will be coming from)

(Phone and Fax number for the institution)

The following information from the patient's clinical record:

Medical information for services rendered:

From: _____ To: _____
(Time period)

Including: _____ Progress Notes _____ Radiology (x-ray) Reports _____ Pathology (Lab) Reports
 _____ Cardiac Tests/ECG/EKG _____ Medications _____ Entire Chart _____ All of the Last 2 Years
 Other _____
 (Explain)

I understand that this information will be used for the purpose of:

____ Referral ____ Insurance ____ Workers Comp ____ Changing Practices ____ Legal Investigation ____ Disability Determination
 ____ Personal ____ Removing/Relocating ____ Continued Care ____ Other _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that in compliance with Iowa statute, I will pay a fee according to the Iowa Industrial Commissioner Administrative Rule 343-8.9. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

X _____ Date _____

Signature of Patient or Guardian or Personal Representative of Patient's Estate.

Specific authorization for release of information protected by state or federal law - I specifically authorize, by writing my initials beside the category and signing below, the release of data and information relating to:

- Substance abuse
- Mental Health
- AIDS/HIV

Signature and date of Patient or Patient's Authorized Representative

Prohibition on Rediscovery

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse, by state law for mental health records or HIV/AIDS related records, federal requirements (42 CFR Part 2) and state requirements (Iowa Code chs.228/141) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS information.

MEDICAL INFORMATION RELEASED BY CARDIOLOGISTS LC

ENTIRE _____ LAB _____ EKG _____
 XRAY _____ OTHER _____
 ROI SPECIALIST _____
 DATE _____