Buchanan County Health Center

Medical Associates – Primary Care
1600 First Street East
Independence, IA 50644
Office: (319) 334-2541
Fax: 319-334-7054

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION:
Name: _____
Date of Birth: _____ SSN: _____ Phone: _____
Address: _____

Release Records From:
Name: _____ Phone: _____
Address: _____

Release Records To:
Name: _____ Phone: _____
Address: _____

Purpose of Release (check all that apply)
☐ Continued Care ☐ Care Coordination ☐ Transfer ☐ Insurance ☐ Legal Representation
☐ Other: _____

Information Requested:
☐ For dates of service: _____
☐ Office visit ☐ Lab work ☐ Radiology Report

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

Initial any category authorized for release:
_____ Genetic testing information or Acquired immunodeficiency syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
_____ Alcohol and drug abuse treatment
_____ Behavior or mental health services

I understand that I may cancel this authorization at any time by sending a written notice to Medical Associates of Buchanan County Health Center, and that my cancellation will take effect when the written notice is received, and it will not apply to information that has already been released in response to this authorization. This authorization will automatically expire 365- days from the date of signature, except as specified.
(Specify expiration date, event, or condition: _____)

I voluntarily authorize the use and/or disclosure of my health information. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity authorized to receive this information is not a health care provider or a health plan that is covered by federal privacy regulations, the released information may be re-disclosed to a third party, and those records may no longer be protected by the federal privacy regulations unless otherwise prohibited from re-disclosure under other federal and/or state laws or regulations. The information released is intended ONLY for the entity or individual listed below and is therefore prohibited from re-disclosure to a third party individual or entity.

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to patient, if not signed by patient: _____

Approved by and date of release: _____