

UROLOGIC ASSOCIATES OF IOWA CITY P.C.
Authorization for Release of Health Information

Please print:

Patient Name _____ Birth Date _____ Social Security Number _____
Last First MI

I understand by signing this form, I am allowing _____
Name of Facility/Provider

Facility Mailing Address/Street/PO Box City, State, Zip Code Fax Number

To Release medical information concerning the above named patient to:

Name of Person and/or Institution

Complete Mailing Address/Street/PO Box City, State, Zip Code Fax Number

Medical Information Requested:

Check the information to be disclosed (included dates where indicated) _____

Minimum necessary or specify:

____ Medication list ____ Allergy list ____ Problem list

____ Most recent history and physical or specific date _____

____ Most recent discharge summary or specific date _____

____ Consultation reports, specify doctor or clinic _____

____ Laboratory results, specify type or date _____

____ X-ray and imaging reports, specify type or date _____

____ Test results (i.e. CMG, EKG, etc), specify type and date _____

____ Billing information, specify _____

____ Other, specify _____

As per my request, the release of information is for ____ medical care ____ egal ____ insurance ____ other

If other, specify _____

I understand I may revoke this authorization at any time by sending written notice to the above named provider of information. I understand that any release, which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the office that disclosed the information.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (initial any category not to be released)

Substance abuse _____ Mental health _____ HIV related information _____

Restrictions: _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____

Signature of patient or legal guardian Date

Complete Mailing Address/Street/PO Box City, State, Zip Code

Relationship if not the patient Witness Signature

FOR OFFICE USE ONLY:

- v Records will be mailed to address above
- v Records will be picked up on
- v Records may be faxed to number listed above

Records prepared by _____
Date prepared _____

rev4-06