

## Authorization to Release Patient Information

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. This release pertains to the named facility only. A copy of this signed form will be provided to the patient upon request.

**I hereby authorize Story County Medical Center, Nevada, Iowa to disclose the following information from the health records of:**

Name: \_\_\_\_\_  
Last First MI Previous Name

Birth Date Social Security # Telephone #s Home Work

Address: \_\_\_\_\_  
Street City State Zip

**This information is to be disclosed to:**

**Covering the periods of healthcare (Date(s) of service:**

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

**For the purpose of:** \_\_\_\_\_  
(not required if the disclosure is requested by patient)

**The following information may be released:**

I understand that this will include information relating to (check and initial if applicable):	
_____	Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
_____	Behavioral health service/psychiatric care
_____	Treatment for alcohol and/or drug abuse

**If compensation will be received:** I understand that \_\_\_\_\_ will receive compensation for its use/disclosure of the information released pursuant to this authorization. \_\_\_\_\_  
Patient initials

### Affirmation of Release

I give \_\_\_\_\_ or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

Signature of Patient/Guardian/Legal Representative \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Witness/Relationship to Patient \_\_\_\_\_ Date Signed \_\_\_\_\_

Expiration Date: \_\_\_\_\_ One year from date signed