AUTHORIZATION TO RELEASE PATIENT INFORMATION

Story Medical CLINICS

☐ Nevada *ph* 515-382-5413 *f* 515-382-7108 ☐ Maxwell *ph* 515-387-8815 *f* 515-387-8817 ☐ Slater *ph* 515-685-3960 *f* 515-685-3961 ☐ Zearing *ph* 641-487-7779 *f* 641-487-7749

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. A copy of this signed form will be provided to the patient upon request.

I hereby authorize the following healthcare provider to disclose the medical record information listed below.

☐ Story Medical Clinic _____ Address: _____

☐ Healthcare provider: _____ City, State: _____

Name: _____
Last First MI Previous name

_____
DOB Telephone #'s Home Work

Address: _____
Street City State Zip

This information is to be disclosed to:

☐ Story Medical Clinic _____ Address: _____

☐ Healthcare provider: _____ City, State: _____

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: (Check appropriate action)

☐ General Hospital Care	☐ Entire Record	☐ Radiology/Imaging	☐ MD Orders	☐ Other
☐ Mental Health	☐ Minimum Data Set	☐ H&P	☐ Nursing Notes	
☐ Substance Abuse	☐ Lab	☐ Operative/Procedure Report	☐ Face Sheet	
☐ HIV/AIDS Related	☐ Emergency Room	☐ MD Progress Notes	☐ Psychotherapy Notes	

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, and by giving written notice to Story County Medical Center. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Story County Medical Center. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations. I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

I acknowledge that information to be released may include material that is protected by state and/or federal law applicable to mental health, alcohol/drug abuse, HIV/AIDS or all of these. My signature authorizes release of all such information as specified above.

Signature of patient/guardian/legal representative: _____ Date signed: _____

Signature of witness/relationship to patient: _____ Date signed: _____

Expiration date: _____ One year from date signed

Nevada, Maxwell, Zearing, and Slater Medical Clinics are affiliates of Story County Medical Center