# IOWA HIPAA MEDICAL AUTHORIZATION RELEASE FORM

I, as the patient or patient's legal representative, authorize _____ **(known as the 'Releasee')**, release and deliver confidential medical information according to this Authorization:

## PATIENT INFORMATION

Name _____ Date of birth _____ SSN _____

Street address _____ City _____ State _____ Zip _____

Phone number _____ Maiden/previous names

_____ **Please provide the name of physician/provider or the specialty which records are needed from** _____ ☐ Send to address above ☐ Send records to the below

Specific records you want sent with service dates _____ Name _____
☐ Billing records ☐ Operative report ☐ Lab data

Street address _____ ☐ Discharge summary ☐ EKG ☐ Radiology reports

City _____ State _____ Zip _____ ☐ History & physical ☐ Radiology films & images

Phone _____ Fax _____ ☐ Complete record ☐ Other _____

Email_____

**PURPOSE OF RELEASE** ☐ Transferring medical care ☐ Insurance coverage ☐ Case coordination/referral ☐ Moving ☐ Legal purposes

☐ Request by patient ☐ Other _____

This authorization is effective for one year from the date on which it is signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it. I understand I have the right to inspect the information to be disclosed upon the proper notification.

The **Releasee** does not require completion of this form as a condition of evaluation or treatment. However, if the evaluation or treatment is solely for the purpose of creating a medical report for a third party, those services are subject to cancellation if authorization to release the information to that party is not provided.

I understand that the person or entity that receives the information requested may not be covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with a covered person or entity and the medical information may no longer be protected by the regulations.

**Electronic transmission of records (Faxing/E-mail)** I authorize electronic transmission (fax/secure e-mail) of my medical records. If any portion of the fax/e-mail is received by an inappropriate third party in error, I release **the Releasee**, its physicians and staff of any and all liability relating to the disclosure of said records. Records may be provided in electronic form on a secure disk. Paper records are available upon request.

I understand that information to be released may include material that is protected by Federal and/or State law concerning mental health, substance abuse treatment, AIDS–related information and genetics unless I specifically deny the release by initialing the category below:

**Please initial beside any category you do NOT want to be released.** Substance abuse (drug or alcohol) _____
Genetics _____ Mental health information _____ AIDS–related information, diagnosis, & test results _____

I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidential information to the person or entity listed above. In order for the information to be released, you must sign below. If mental health information is being disclosed, I acknowledge receipt of a copy of this authorization.

Signature of patient or patient's legal representative_____Date_____

Printed name and relationship of patient's legal representative_____
*(Authority to act on behalf of patient requires attachment of such documentation)*