Des Moines University Clinic
3200 Grand Ave., Des Moines, IA 50312
Health Information Management Dept.
Phone (515) 271-7836 Fax (515) 271-1726

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The Medical Records Of: (Patient name)

Name:_____ Date of Birth: _____

Address:_____ City:_____ State:___ Zip:_____

Phone: _____

I give Des Moines University Clinic permission to: Check one and fill out

____ **send medical records to** **(or)** ____ **obtain medical records from:**

Name:_____

Address:_____ City:_____ State:___ Zip:_____

Phone: _____ Fax:_____

The following medical information may be released: ___ all information or

___Progress Notes ___Lab ___X-ray report ___Tests results ___Immunizations

___Billing Other_____

Specify physician if needed _____

Reason for the release: ___Medical Care ___Immunizations ___Transfer of care

___Insurance ___Legal Other:_____

The effective date of this authorization is one year from date of signature or until specified. Affirmation of Release: Copies of my records may be obtained with reasonable notice and payment of copying costs, if applicable. I give DMU Clinic or the named agency permission to release the information I have selected on this form to the individual(s) or agency(s) I have named for the purpose I have listed. I understand that I may revoke this authorization in writing at any time by submitting a statement to the Health Information Manager. Any revocation 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 and does not relate to any disclosure made before the revocation is received. Prohibition on Re-disclosure: Certain medical information is protected by state and federal law. Re-disclosure of this protected information is prohibited without the express consent of the patient or as otherwise permitted by law. A general release of medical information is not sufficient for these purposes. This form does not authorize re-disclosure of protected health information. I further understand that the person or entity that receives the information may re-disclose it and not have to obey federal privacy laws.

x_____ _____
Signature of Patient or Legal Representative Date

I specifically authorize the release of any information I have marked "Yes":

_____ HIV / AIDs Diagnosis and/or Treatment
_____ Substance Abuse (alcohol and/or drug) treatment
_____ Mental Health

x_____ _____
Signature of Patient or Legal Representative Date

For Office Use Only: Records / Request

Acct#/MRN# _____ Tote # _____ Storage box # _____
Initials and date of person taking request _____

____Mail ____Fax Initials/Date Completed _____

____To be picked up / Date Picked Up/Initials _____
Records not picked up / Date destroyed/Initials_____

____There are no charges for the copies of records for this request
Charges in the amount of _____ have been / have not been received for this request.
____*Verbal/phone request* (for immunizations / pick-up / or other medical facility only)