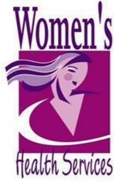

Women’s Health Services

2635 Lincoln Way, Clinton IA 52732 • 229 S Main St, Maquoketa, IA 52060
Phone: 563-243-1413 • Fax: 563-242-9992

Authorization for Release of Medical Information

Patient Name:______________________ Date of Birth:____________ Social Security #:______________

Address:______________________ City/State/Zip Code:______________________

Phone #:______________________ Previous Name/s:______________________

Date of Request:______________________ **Date Needed:**______________________

Transferring Records From WHS		Transferring Records To WHS
I authorize WHS **to release information to:**	OR	I authorize WHS **to obtain information from:**
Name of Provider or Facility		Name of Provider or Facility
Address		Address
City, state, Zip Code		City, state, Zip Code
Phone# Fax#		Phone# Fax#

By signing this form, I am allowing Women’s Health Services to release/request medical information concerning the above named patient to the person or facility listed above.

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

Mental Health* ___yes ___no Substance Abuse** ___yes ___no HIV ___yes ___no

Signature:______________________ Relationship:______________________

Please check the reason for the information to be disclosed: (Include dates if known) ☐ Transfer of Care
☐ Moving ☐ Personal File ☐ Insurance ☐ Legal ☐ Personal Use ☐ Continuing Care (Non-OB/GYN Provider)
☐ Other:______________________

Please list the information to be disclosed: (Include dates if known)
☐ Copy of entire medical record, as allowed by law. (Applies to all records released from Women’s Health Services.)
☐ Other:______________________

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to Women’s Health Services, 2635 Lincolnway Ste A, Clinton, IA 52732. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) 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 Women’s Health Services.

Women’s Health Services does not require completion of this form as a condition of evaluation of treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.

This agreement will expire one year from the date of signature, or as indicated (specify number of days or months) ____________unless cancelled by the patient/guardian.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Signature of Patient or Representative:______________________ Date:______________

Relationship to Patient (if requester is not the patient):______________________