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:_____
Address:_____	Social Security #:_____
Phone #:_____	City/State/Zip code:_____
Date of Request:_____	Previous Names:_____

Transferring Records From WHFS	Transferring Records to WHFS
I authorize WHFS **to release information to**:	I authorize WHFS to o**btain 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 & Family 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 record as allowed by law (Applies to all records released from Women's Health & Family 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 & Family Services 2635 Lincoln Way Suite A, Clinton, Iowa 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, & 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 & Family Services.

Women's Health & Family 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 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 # 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 requestor is not the patient):_____