

# Authorization to Release Medical Records

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
SSN # \_\_\_\_\_ Phone # \_\_\_\_\_

I authorize the use or disclosure of the above mentioned individual's health information as described below:

I hereby authorize the release of my medical records FROM:

<input type="checkbox"/>	Family Medicine Clinic	OR	<input type="checkbox"/>	Name _____
	194 6th Ave NE			Address _____
	Le Mars, IA 51031			City, State, Zip _____
	712-546-8113 phone			Phone _____
	712-546-9307 fax			Fax _____

Information to be released:

<input type="checkbox"/> Any and all records	<input type="checkbox"/> Hospitalization Records	<input type="checkbox"/> Other _____
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Labs	
<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> History & Physical	

Purpose of Disclosure:

<input type="checkbox"/> Transferring Care	<input type="checkbox"/> Continued Healthcare	<input type="checkbox"/> Moving	<input type="checkbox"/> Other
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I specifically authorize the release of data and information relating to:

<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Mental Health	<input type="checkbox"/> HIV related
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Health Information to be disclosed TO:

<input type="checkbox"/>	Family Medicine Clinic	OR	<input type="checkbox"/>	Name _____
	194 6th Ave NE			Address _____
	Le Mars, IA 51031			City, State, Zip _____
Provider _____				Phone _____
				Fax _____

I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Records Department. I understand this revocation will not apply to information already released in response to this authorization. This authorization will expire on the following date, event, or condition: \_\_\_\_\_ If I fail to specify an expiration date, event or condition, this authorization shall be in effect for one year from the date it was signed.

I release Floyd Valley Hospital Family Medicine Clinics or identified agency, its employees, officers, and physicians from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date



## Floyd Valley Hospital

Family Medicine Clinic – Le Mars

*An Avera Partner*

194 6th Ave NE  
Le Mars, Iowa 51031

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712-546-9307 fax