



1115 South Marshall Street • Boone, Iowa
(515) 432-2335 • www.boonehospital.com

Authorization to Release Patient Information

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient. This authorization may be revoked by the patient at any time. **PLEASE PRINT CLEARLY**

Name _____
Last First MI Previous Name
/ / H W
Birth Date Social Security # Telephone #'s

Address: _____
Street City State Zip

This will authorize:

(NAME)

(ADDRESS)

(CITY/STATE/ZIP)

To Release to:

(NAME)

(ADDRESS)

(CITY/STATE/ZIP)

Medical Information Requested:

- Complete Records
- Lab
- X-Ray Reports
- X-Ray Films / Disc
- Immunization
- OB Flow Sheet
- Other _____

Reason for Release:

- To update my regular doctor (provider)
- I have been referred to another doctor
- I want/need a second opinion
- I am changing doctor (provider)
 - Dissatisfaction with care
 - My insurance changed
 - I am moving (New Address)
- Other _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to *(Note, you must initial & mark yes or no)*

Initial	YES	NO	
_____	<input type="checkbox"/>	<input type="checkbox"/>	1. Treatment for alcohol and/or drug abuse
_____	<input type="checkbox"/>	<input type="checkbox"/>	2. Behavior health service/psychiatric care
_____	<input type="checkbox"/>	<input type="checkbox"/>	3. Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection

Affirmation of Release: I give _____ or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to the expiration date stated below and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization 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. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations. This authorization will automatically expire one year from date of signature or until _____ 20_____.

Signature of Patient or Legal Gaurdian _____ Date _____
Relationship, if not the Patient _____ Daytime Phone # _____

For Clinic Use Only

Reviewed & Approved by Dr. _____ Patient Pick up Date Needed _____
Completed by _____ Date: _____