SPENCER CONVENIENT HEALTHCARE, LLC
SPENCER, IA 51301
P:712-580-6592 F:712-580-6593

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone:(Home)_____ **Phone:(Cell)**_____

Address:_____ **City/State/Zip:**_____

Please Note: Please Allow 5 Business Days For Processing. Copy Fee May Be Charged For Medical Records.

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:_____ **Facility Phone:**_____

Facility Address:_____ **Facility Fax:**_____

CITY,STATE,ZIP:_____

Dates and Type of information to disclose:

- ☐ All-Entire Record
- ☐ Dates other:_____
- ☐ Specific Information requested:_____

_____

The Purpose of disclosure is:

- ☐ Change insurance or physician
- ☐ Continuation of care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other_____

Release To:_____

Address:_____

City/State/Zip:_____

Fax:_____ **Phone:**_____

- ☐ **Please Mail Records**
- ☐ **Please Fax Records**

RESTRICTIONS: Only medical records originated through this Spencer Convenient Healtcare will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. This Authorization is good for one year of signed date.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response tot his authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that and disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

SIGNATURE:_____Date:_____

WITNESS:_____