AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Maiden / Other Name _____ SSN # _____

Address _____ Phone # _____

City, State, Zip _____

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

I hereby authorize the release of my records FROM:

☐ Floyd Valley Healthcare
714 Lincoln St. N.E.
LeMars, IA 51031
712-546-7871 Phone
712-546-3416 Fax

☐ Floyd Valley Clinic
714 Lincoln St. N.E.
LeMars, IA 51031
712-546-8113 Phone
712-546-9307 Fax

☐ Name _____
Address _____
City, State, Zip _____
Phone # _____
Fax # _____

Information to be released:

☐ ANY and ALL records
☐ Immunization records
☐ X-Ray reports
☐ History & Physical
☐ Hospital Records
☐ Labs
☐ Dates of Service _____ to _____
☐ Other _____

Purpose of Disclosure:

☐ Transferring Care ☐ Continued Healthcare ☐ Moving ☐ Other _____

Protected Health Information may include information and records protected under Federal and State Law such as:
alcohol, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or non-communicable disease. I specifically authorize the release of these records. ☐ Check box and initial _____

Health Information to be released TO:

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LeMars, IA 51031
712-546-8113 Phone
712-546-9307 Fax
Provider: _____

☐ Name _____
Address _____
City, State, Zip _____
Phone # _____
Fax # _____

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 one year from the date signed. 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 the revocation will not apply to information already released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed. I understand all information disclosed, according to this authorization, may be subject to re-disclosure by the recipient and may be no longer protected by federal law.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

In office use only:
Date information disclosed _____
By Whom _____

FV.ROI

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Approved by Risk Management: 5/13/10, 12/12/13
Revised 4/2/12, 11/20/13, 2/12/14, 10/28/16