



Authorization for Release of Confidential Health Information (From our office to an outside entity)

For Office Use: Start Date: End Date: Rescind Date:

I hereby authorize Dubuque Obstetrics & Gynecology, P.C. to release information to:

Agency Name Street / Mailing Address City State Zip

From the patient record of:

Patient Name Maiden Name Birth Date Social Security #

I am requesting the information listed below for the following time period: from: to .

- Medical records generated by Dubuque Obstetrics & Gynecology, P.C., including mental health treatment, alcoholism treatment, drug abuse treatment, and HIV / AIDS records
Information necessary to process FMLA and / or disability claims, including mental health or HIV / AIDS records (we do HIV testing on all pregnant patients).
Other:

The purpose(s) of the authorization is (are)

- FMLA or disability related Shared medical care Other Transferring care Insurance Underwriting

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the practice has already relied on it to use or disclose my health information. Written revocation must be sent to the practice's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on . (Not to exceed one year, or if no date is specified, one year from date of signing.)

Signed: Date:

If you are not the patient, please specify your relationship to the patient:

MEDICAL RECORD FEES (to be paid in full prior to release of information):

- Dubuque Obstetrics & Gynecology, P.C. will fulfill one record request for free. The charge for each additional copy is \$5 for 1-99 pages and \$5 for each additional 100 pages.
The fee for all life / accident / disability insurance applications is \$25.
The fee for a copy of records generated by another health care provider is \$20.

Based on a review of your records, the fee is: \$0 \$5 \$10 \$15 \$20 \$25

Return this release and remit the fee to: Dubuque Obstetrics & Gynecology, P.C. 1500 Delhi Street, Suite 3100 Dubuque, Iowa 52001