Dubuque Ob Gyn

Authorization for Release of Confidential Health Information

(From an outside entity to our office)

I hereby authorize: _____

Agency Name

_____

Street / Mailing Address

_____

City **State** **Zip**

To release information to: **Dubuque Obstetrics & Gynecology, P.C.**
1500 Delhi Street, Suite 3100
Dubuque, Iowa 52001-6319
Phone: (563)557-5959 Fax (563)557-5950

From the patient record of:

_____ _____
Patient Name **Maiden Name**

_____ _____
Address **Birth Date**

_____ _____
City **State** **Zip** **Social Security #**

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

From: _____ to _____.

☐ Medical records generated by the entity, ***including*** mental health treatment, alcoholism treatment, drug abuse treatment, and HIV / AIDS records
☐ Other: _____

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

☐ Shared medical care ☐ Transferring care to our office
☐ Other _____

- 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 physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician'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: _____.