Dubuque Ob Gyn

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