

Mary Greeley Medical Center
Authorization to Release and/or Receive Medical Information
(There may be a **FEE** associated with releasing these records)

Patient Name: _____
DOB: _____ SSN: _____ Phone _____
Address: _____

I hereby authorize Mary Greeley Medical Center to:
 Release copies of billing or medical records to the following persons or entries.
 Receive copies of billing or medical records from the following persons or entries.

Release my records to: _____

I authorize FAXing my records _____(initial) to _____(phone #)

The following information shall be obtained and/or released pursuant to this authorization:

Please Initial:

- Name, address, phone number
- Social Security Number
- Date of Admission
- Findings of physical examination

Admission Dates Requested:

Please Initial:

- Abstract (Dictations & test results)
- Discharge Note
- Operative Note
- Progress Note
- Consult Note
- Pain Clinic Notes
- History and Physical
- Labs
- Listings of Films/X-ray(s) reports
- ER Note
- Complete Record

Specific Authorization For Release Of Information Protected By State Or Federal Law

I specifically authorize the release of information relating to: (Patient must initial appropriate line(s)):

- Substance Abuse
- Mental Health - I have the right to inspect the disclosed mental health information at any time.
- Acquire Immune Deficiency Syndrome (AIDS) including Human Immuno-deficiency Virus (HIV test results).

Signature/Date

In Order For The Above Information To Be Released, You Must Sign Here And Below.

The information will be obtained and/or disclosed for the following reason(s):

- At the request of the individual
- Assessment & Evaluation
- Marketing
- Legal Reason
- Treatment/Continuity of Treatment
- Other

This authorization will expire _____ **Six months** from the date of the signature below,
or **Other:** _____

Notice to Patient/Patient Representative: If the recipient of the information disclosed pursuant to this Authorization is not a health care provider, health plan or health care clearinghouse, the information may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

This Authorization may be revoked by notifying Mary Greeley Medical Center in writing addressed to:
Privacy Officer
Mary Greeley Medical Center
1111 Duff Avenue
Ames, IA 50010

Note: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effectively only as of the date it is received by Mary Greeley Medical Center.

Patient Signature

Date

Personal Representatives/ Relationship/Authority

Personal Representative/Relationship/Authority

This authorization is voluntary. A refusal to sign will not affect the patient's ability to obtain treatment, payment, or if applicable, enrollment in a health plan or eligibility of benefits.