IOWA RETINA CONSULTANTS
www.iowaretina.com

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Authorization for Release of Medical Information

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulation.

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Iowa Retina Consultants. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Iowa Retina Consultants.

Date Information Requested: _____ Date Information Sent: _____

Patient Identification: Name: _____
Birthdate: _____ Social Security No.: _____

Provider Information: Name: _____
Address: _____

Requestor Information: Name: Iowa Retina Consultants
Address: 1501 50th Street, Ste. 133, West Des Moines, IA 50266

Purpose of Release: _____ Transferring Medical care
_____ Other _____

I understand that my healthcare and payment for my healthcare will not be affected by this authorization.

Patient or Legal Representative Signature: _____ **Date:** _____

Relationship to Patient (if not signed by patient): _____

Specific Authorization for Release of Information Protected by State or Federal Law:

I specifically Authorize the release of information relating to:

Substance Abuse Treatment: Yes _____ No _____
Mental Health: Yes _____ No _____
HIV/Aids: Yes _____ No _____

This information does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Patient or Legal Representative Signature: _____ **Date:** _____

Relationship to Patient (if not signed by patient): _____