Piper Family Medicine, PC

4000 RIVER RIDGE DR NE, Suite 2
Cedar Rapids, IA 52402
p: (319) 261-1379
f: (319) 261-1382

Medical Records Release Request

Patient Legal Name: ______________________________

Date of Birth: ______________________ Telephone: ______________________

Address: ______________________________

City: ______________________ State: ____________ Zip: ____________

I hereby authorize the release of my Protected Health Information as follows:

◯ From: ◯ To:

Name of Facility: ______________________________

Physician: ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

◯ From: ◯ To:

Piper Family Medicine, PC
Scott Piper, MD
4000 RIVER RIDGE DR NE, Suite 2
Cedar Rapids, IA 52402

Phone: (319) 261-1379
Fax: (319) 261-1382

Purpose of Release: ______________________________

Type of Information to be Released:

◯ Entire Medical Record (including sensitive information as described below)

◯ Entire Medical Record EXCLUDING ◯ Mental Health ◯ HIV testing/results ◯ Substance Abuse

◯ A Summary of my Medical Record (which may include sensitive information as described below)

Specific Information Only: ______________________________

Sensitive Information:
I am aware that my medical record may contain sensitive information include drug or alcohol abuse diagnosis and treatment; sexually transmitted diseases and HIV/AIDS testing or treatment; mental health diagnosis and treatment; sexual identity, preferences, and practices; genetic testing and family history.

Release Expiration:

◯ At the fulfillment of this release ◯ On specified date: ______________________

______________________________ ______________________
Patient/Legal Guardian Signature Date