4000 River Ridge Dr. NE, Ste 2
Cedar Rapids, IA 52402
P:319-261-1379
F:319-261-1382

PROTECTED HEALTH INFORMATION RELEASE

Patient Name: _____

Messages:

Please call my [ ] Home [ ] Work [ ] Cell Number_____

- ❑ If unable to reach me:
  - ❑ You may leave a detailed message regarding my medical care and test results
  - ❑ Please leave a message asking me to return your call
  - ❑ Other_____
- ❑ Send me appointment reminders
  - ❑ By text to #_____
  - ❑ By email to _____

Release of information:

I authorize the release of information including but not limited to diagnosis, records, images, examination rendered to me, claims/billing information, to the following individuals. (*Please list all individuals authorized by this release*)

- ❑ Name:_____

  Relation:_____#_____
- ❑ Name:_____

  Relation:_____#_____
- ❑ Name:_____

  Relation:_____#_____
- ❑ Name:_____

  Relation:_____#_____
- ❑ Information is not to be released to anyone

- ☐ This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- ☐ This authorization will remain in effect for 1 year or until _____(date), at which time this authorization expires.
- ☐ Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released. I also understand the disclosure of this information is voluntary.
- ☐ I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- ☐ I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or guardian

_____

Printed name of patient or guardian and his/her relationship to patient

_____

Date