Authorization to Release Medical Records

Name of Patient ______________________________ Date(s) of Service __________________________

Date of Birth _________________________________ Phone number _____________________

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care
Military
Social Security/Disability
Insurance
Personal Use
Legal Purposes
School: ________________________
Other: ___________________________

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical
Consultation Report
Emergency Room Record
Operative Reports
Discharge/Death Summary
Face Sheet
Lab/Path Reports
X-Ray Reports/Images
Other: _______________

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

____

Address (Street, City, State and ZIP)

FROM:

Dr Timothy Holcomb, DPM Foot and Ankle of Greater Des Moines PC

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

515-631-9567 515-349-8578

Phone Number Fax Number

550 36th AVE SW, Ste F Altoona, IA 50009

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time (See CFR §164.508(c)(2)(i-iii).

Signature: ____ Date: ____________________

____ _____________________

Printed Name of Patient or Legally Authorized Representative Relationship to Patient