SURGICAL SERVICES, P.C. **Medical Records Release Authorization**

510 E Bloomington St. Iowa City, IA 52245 phone 319-3389247 fax 319-338-2785

Medical Records cannot be released until this form is completed, signed and returned to Medical Records at Surgical Services PC. (Please Print)

1. Patient Information

Name: ______________________________

Date of Birth: ______________________ Telephone # ______________

Street: ______________________________

City: ______________________ State: __________ Zip: __________

Day / Work telephone #: ______________________ ☐ S.S.N. ______________

2. Type of Release Authorization

☐ I authorize Surgical Service, PC to **RELEASE** medical records information to: __________
____

☐ I authorize Surgical Service, PC to **OBTAIN** medical records information on me from:
Name: ______________________________
Street: ______________________________
City: ______________________ State: __________ Zip: __________

3. Purpose for Request

☐ At the request of the patient ☐ Transfer of records to new physician
☐ Other, please specify: ______________________________

4. Information needed (include dates where appro-priate and check off all that apply.)

☐ The entire medical record, ***excluding*** mental health treatment, drug abuse treatment, and HIV/ acquired immune deficiency syndrome (AIDS) records
☐ History & physical from date ______________ to ______________
☐ Laboratory results from date ______________ to ______________
☐ X- ray results from date ______________ to ______________
☐ Other: ______________________________

5. Authorization (Mandatory)

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that Surgical Services, P.C. may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating health information for the disclosure to a third party.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
I understand that this authorization is valid until it expires, unless otherwise revoked, this authorization will expire on the following date *(no longer than 12 months)*: ______________________. If I fail to specify expiration date this authorization will expire 1 year from now. I understand that I may revoke this authorization at any time by giving written notice. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to SURGICAL SERVICES, PC.

Patient's or Legal Representative's Signature: ______________________ Date: __________
If signed by Legal Representative, relationship to patient: ______________________
Witness' Signature: ______________________ Date: __________

(over please)