AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____

Address:_____ Phone #:_____

City, State, Zip:_____

I authorize the use or disclosure of the above mentioned individual's health information as described below:

I hereby authorize the release of my records FROM:

☐ David Wolff MD, PLLC
19564 C 16
Akron, Iowa 51001
Phone: 712-266-3033
Fax: 515-666-8960

☐ Name_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____

Information to be released:

☐ ANY and ALL records ☐ History & Physical ☐ DOS:_____to_____
☐ Immunization records ☐ Hospital Records ☐ Mental Health
☐ X-ray reports ☐ Labs ☐ Other_____

Purpose of Disclosure:

☐ Transferring Care ☐ Continued Healthcare ☐ Moving ☐ Other_____

Form and Format:

☐ Paper records ☐ Flash Drive ☐ Fax ☐ CD ROM

☐ Email (All email transmissions will be sent encrypted.) If you choose to have your records sent via email please provide us with your email address:_____

Check this box only if you **DO NOT** permit substance abuse records to be released. ☐ Requestor, take note: These released records contain substance abuse documentation and therefore prohibition on redisclosure applies. **This information is released subject to the confidentiality provision of federal statues (42 U.C.S. 290dd-2 and regulations 42CFR, Part 2)** which prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

☐ David Wolff MD, PLLC
19564 C 16
Akron, Iowa 51001
Phone: 712-266-3033
Fax: 515-666-8960

☐ Name_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____

Unless otherwise revoked, this authorization will expire on the following dates, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed. I understand I have the right to revoke this authorization at any time by presenting a written revocation to the Medical Records Department. I understand the revocation will not apply to information already released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed. I understand all information disclosed, according to this authorization, may be subject to re-disclosure by the recipient and may be no longer protected by federal law.

_____ _____
Signature of patient or legal representative Date

_____

Relationship to patient