2900 Westown Pkwy, Ste 130
West Des Moines, IA 50266

Focused Life CLINIC

Phone: 515-227-6065
Fax: 833-907-2405

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

*Please complete ALL sections. Failure to do so could prevent or delay processing.

PATIENT INFORMATION Enter the patient's information in this section	First and Last Name: _____ Date of Birth: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Email: _____
INDIVIDUAL OR ENTITY SENDING AND/OR RECEIVING RECORDS	Check all that apply: ☐ Focused Life Clinic is authorized to **release** information to the following ☐ Focused Life Clinic is authorized to **receive** information from the following
	Name of Person or Entity: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____ Fax: _____
DATES OF REQUESTED INFORMATION	☐ Any and all dates ☐ Specific dates: _____ to _____
INFORMATION REQUESTED Please check all that apply	☐ Complete record ☐ History & Physical ☐ Medication record ☐ Progress notes ☐ Lab results ☐ Imaging/testing reports and results ☐ Other (please specify): _____
SPECIFIC AUTHORIZATION Check either YES (release) or NO (do not release) in each line	Mental Health ☐ YES ☐ NO Substance Use/Abuse ☐ YES ☐ NO HIV/AIDS related information ☐ YES ☐ NO
INFORMATION FORMAT Please check all that apply	☐ Fax ☐ Mail ☐ Pick-up ☐ Email:_____ ☐ Verbal Exchange of Information
EXPIRATION:	This authorization is effective for one year from the date on which it was signed unless otherwise specified here: _____
REVOCATION: You may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Focused Life Clinic.	
FEES: Focused Life Clinic may charge a fee to cover the cost of labor, copying, and preparation of the requested information. Said charge shall be paid prior to collecting, copying, or preparation of requested information.	
RE-RELEASE: Recipients of this information may possibly re-release the information without proper authorization and once information is disclosed it may no longer be protected by federal privacy regulations.	

PATIENT STATEMENT

By signing below, I acknowledge that I have read, understood, and agree to the terms of this Authorization and I authorize this disclosure. I also acknowledge receipt of a copy of this Authorization.

_____ _____

Signature of Patient/Legal Representative/Legal Guardian **Date**

_____ _____

Printed Name of Patient/Legal Representative/Legal Guardian Relationship to Patient if Signed by Legal Representative/Guardian