

Mid-Iowa
FERTILITY
Extraordinary Care...
Extraordinary Results

Authorization for Release of Protected Health Information (PHI) To Mid-Iowa Fertility

PATIENT LAST NAME: _____ PATIENT FIRST NAME _____
PATIENT DATE OF BIRTH _____ SSN #: _____
TELEPHONE NUMBER () _____

I hereby request that the following health care provider or entity release/disclose my protected health information to **Mid-Iowa Fertility**, located at 1371 NW 121st St., Clive, IA 50325 (Fax: 515-222-9563)

Name: _____
Address: _____
City, State, Zip Code _____
Phone: ____ () _____

The information released shall include (check that which applies):

- _____ My entire medical record (no more than the past 5 years, unless otherwise specified)
- _____ Portions of my medical records pertaining to: _____
- _____ A specific date of service or test result: _____
- _____ Other: _____

Reason for release:

- _____ Further specialty medical care _____ Personal use _____ Moving out of area
- _____ Transferring to a new provider _____ Other (specify) _____

Additional Release

I agree to the release of information regarding the following:

HIV/Hepatitis status	_____	_____
	Initials	Date
Drug/Alcohol Abuse	_____	_____
	Initials	Date
Mental Health	_____	_____
	Initials	Date

No information regarding these areas of care will be included in the records released unless specific authorization is provided.

I understand that (1) my records are protected under Federal Health Insurance Portability and Accountability Act (HIPAA) law, as well as State of Iowa laws, (2) under HIPAA law, I have the right to review and request amendments to my records, where appropriate, (3) this authorization is applicable only for services provided on or before the date of this authorization, *unless* specifically stated otherwise in this authorization.

PATIENT SIGNATURE: _____ DATE: _____
SIGNATURE OF LEGAL GUARDIAN (if applicable) _____