Mid-Iowa
FERTILITY
Extraordinary Care…
Extraordinary Results

Authorization for Release of Protected Health Information (PHI)

PATIENT LAST NAME: _____ PATIENT FIRST NAME_____

PATIENT DATE OF BIRTH _____ SSN #: _____

TELEPHONE NUMBER ( ) _____

I hereby request that **Mid-Iowa Fertility** release/disclose my protected health information via mail or fax (circle one) to:

Name: _____

Address: _____

City, State, Zip Code _____

Phone: __(____)_____FAX: _(_____)_____

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_____ _____ *Drug/Alcohol Abuse _____ _____ *Mental Health_____ _____

Initials Date Initials Date Initials Date

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

Right to Revoke:

You have the right to revoke this authorization at any time in accordance with our Notice of Privacy Practices. You can at any time revoke this authorization by submitting notice in writing to the address below. Your revocation shall not apply to those uses and disclosures we made on your behalf prior to your written revocation.

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, (4) there is a copying fee of $10.00, plus $.25 per page for every page over twenty (20) pages. Payment must be received prior to the release of records. This fee is waived if records are being released to another health care provider or entity.

PATIENT SIGNATURE: _____ DATE: _____

Expiration: This authorization shall expire 180 days from the date authorized.

SIGNATURE OF LEGAL GUARDIAN (if applicable) _____

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