ENT MEDICAL SERVICES PC
2615 Northgate Drive
Iowa City, IA 52245-9565
Phone: (319) 351-5680 Fax: (319) 351-8980

Thomas A Simpson, MD
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# RELEASE OF MEDICAL RECORDS

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ DOB: _____ Acct #: _____

**I hereby REQUEST THAT MY MEDICAL RECORDS BE RELEASED. The use or disclosure of my protected health information is described below.**

1. Specific description of information that may be **released**. (Check appropriate line):

   ☐ Discharge summary letters and clinical notes pertaining to Patient's evaluation and treatment.

   ☐ Other (describe): _____

1. (Optional) This information will be **released/used** for the following purpose(s) (i.e., continuing medical care, second opinion etc.)

   ☐ At the request of the individual.

   ☐ Other (describe): _____

2. Person/organization authorized to RELEASE the information:

   **ENT Medical Services**
   **2615 Northgate Drive**
   **Iowa City, IA 52245-9565**

3. Persons/organizations authorized to **RECEIVE** the information:
   **Include FAX # of where to send records →**

4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment payment for or coverage of services, or ability to obtain treatment, except if (a) the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization. ENT MEDICAL SERVICES PC reserves the right to deny treatment associated with such research: or (b) the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, ENT MEDICAL SERVICES PC reserves the right to deny that health care.

5. I understand that I may inspect or copy the information used to or disclosed.

6. I understand that I may revoke this authorization at any time by notifying ENT MEDICAL SERVICES PC in writing, exact to the extent that: (a) action has been taken in reliance on this authorization; or (b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

7. If this authorization is requested by ENT MEDICAL SERVICES PC or involves the disclosure of mental health information, I acknowledge receipt of a copy of the authorization.

8. This authorization expires on/upon _____ not to exceed one year.

9. I understand that if the person or entity that receives the information requested is not covered by federal or state privacy laws or is not an individual or entity who has signed an agreement with such a person or entity agreement to maintain the confidentiality of the information, the information described above may be redisclosed and will no longer be protected by law.

**Signature of patient or patient's representative** **Date**

**PRINTED** name of patient or patient's representative Relationship to patient or representative's authority to act for the patient

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# SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and/or AIDS-related information. I specifically authorize the release of confidential information relating to: [Mark "YES" or "NO" in ALL applicable boxes:]

**YES** _____ **NO** _____ Substance Abuse (Drug or Alcohol) Information from: _____

**YES** _____ **NO** _____ Mental Health Information from: _____

**YES** _____ **NO** _____ AIDS-related Information, diagnosis, and test results from: _____

*Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug or mental health information must be accompanied by the following written statement:*

**PROHIBITION ON REDISCLOSURE**

This form does not authorize the disclosure of medical information beyond the limits of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and state requirements (Iowa Code Chapter 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

In order for the above information to be released, you must sign here **AND** at the end of page 1.

_____ _____
**Signature of patient or patient's representative** **Date**

_____ _____
**PRINTED** name of patient or patient's representative Relationship to patient or representative's authority to act for the patient

**PATIENT MUST RECEIVE COPY OF COMPLETED FORM**