SMCH
1301 W. Main
Lake City, IA 51449
712-464-3171
Fax: 712-464-1108

McCrary-Rost Clinic
1800 W. Main St.
Gowrie, IA 50543
515-352-3891

McCrary-Rost Clinic
1351 W. Main
Lake City, IA 51449
712-464-7907

McCrary-Rost Clinic
1160 3rd St.
Lake View, IA 51450
712-665-8555

McCrary-Rost Clinic
505 E. Lake St.
Rockwell City, IA 50579
712-297-8989

Authorization for Release of Medical Information

This authorization is effective for _____ months but no longer than 1 year from the date on which it was signed. I understand that I 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 the Medical Records Department of the source facility. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the source facility. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. I understand that I am entitled to receive a copy of this completed authorization form.

INSTRUCTIONS:	***Make sure all blanks are filled in. Failure to do so could prevent or delay processing.***
PATIENT IDENTIFICATION	Name (last, first, middle initial): _____ Date of Birth: _____ Last 4 digits of Soc. Sec.#: _____ Any previous names under which records may be kept: _____ Telephone number where we can reach you if we have questions: _____
PROVIDER (Who is to disclose the information?)	☐ SMCH ☐ McCrary-Rost Clinics ☐ SMC MR Behavioral Health ☐ Other entity (please specify): _____ Street address: _____ City, State and Zip: _____
RECIPIENT (Who is to receive the information?)	Name: _____ Street address: _____ City, State and Zip: _____ Telephone number: _____ Fax number (if applicable): _____
PURPOSE OF RELEASE:	**(Check all that apply)** ☐ Continuing Care ☐ Insurance Coverage ☐ Legal ☐ SSA/Disability ☐ Personal Use ☐ Other _____
Requested Format:	☐ Paper ☐ CD ☐ Other _____
Information (What information should be released?)	**(Check all that apply)** ☐ Records dating from: _____ to: _____ ☐ Provider Notes ☐ Emergency Room Record ☐ Complete Record ☐ Lab Reports ☐ X-ray Reports / ☐ Images ☐ Billing Statement ☐ Other: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I authorize the release of the information listed below, which requires specific consent under federal law: **(check all that apply) (Note: Depending on what is checked we may be unable to fulfill this authorization.)**

☐ Substance Abuse ☐ Mental Health Treatment (excluding psychotherapy notes) ☐ HIV/AIDS related testing

Signature of Patient or
Authorized Representative: X_____ Relationship:_____

Signature of patient or legal representative: _____ Date: _____

Relationship to patient, if signed by legal representative: _____

Prohibition of Redisclosure

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health and HIV/AIDS records, federal requirements (42 C.F.R., Part 2) and state requirements (Iowa Codes Chapters 228 and 141.23) prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by law or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS-related information.

Completed by: _____ Date: _____