SIOUXLAND MEDICAL EDUCATION FOUNDATION
2501 Pierce Street, Sioux City, IA 51104

Phone: 712-294-5000
Fax: 712-294-5092

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____
First Mi Last Name Maiden Name

DOB: ____________________ SS #: ______ - _____ - ________
Month / Day / Year

Address: ______________________________ City: ________________ State: ______ Zip: __________

Daytime Phone: _________________________ Evening Phone: ___________________________

I hereby authorize ____ located at:

Address: ______________________________ City: __________ State: _____ Zip: ________

to obtain and release information from my medical record as indicated below to: **SMEF – FMC**

Address: ***2501 Pierce Street, Sioux City, IA 51104***

Phone Number: ***712-294-5000*** Fax: ***712-294-5092***

Dates of Treatment: From: ____________________ ***to*** ____________________

Purpose of Disclosure:
- ☐ Changing Physicians
- ☐ Consultation/Second Opinion
- ☐ Continuing Care
- ☐ Legal
- ☐ School
- ☐ Insurance
- ☐ Workers Compensation
- ☐ Other (please specify): ______________________

Information to be Released:
- ☐ History and Physical Exam
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ X-ray Reports
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Entire Health Records (including, but not limited to, information regarding medical/health treatment, demographics, and referral documents.)
- ☐ Other: Please specify ____

I specifically authorize the release of information relating to: *The patient will **initial** the appropriate response*.

Yes _____ No _____ Substance Abuse (including alcohol/drug abuse)

Yes _____ No _____ Psychiatric/Mental Health treatment records.

Yes _____ No _____ HIV related information (AIDS related testing)

Read Carefully.

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- Unless revoked earlier or otherwise specified below, this authorization will automatically expire one year from the date I signed this authorization.
- I understand that by authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
- I understand I may inspect and/or receive a copy the information described on this form if I ask for it.
- I understand that in compliance with Iowa statute, I will pay a fee for copy of, supervision of or for summarizing the record. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment. Total amount of fee charged: $______________ Total amount of fee collected: $ ___________
- I have been informed that ______________________ (Print Name of Provider)
  ☐ will ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

____
Signature of Patient (or Patient Representative)

____
Date

____
Printed Name of Patient or Patient Representative

____
Relationship to Patient

Date Request Filled: ______________________________

By: ______________________