# Eastern Iowa Brain & Spine Surgery, PLLC

## Authorization for Release of Medical Information

Patient Name (Print): _____________________________________________ Date of Birth: ___________

S.S. No.: _________________ Phone: (home/cell) _________________ (work)__________________

Address: ___________________________________________________________________________

City: ____________________________ State: _____ Zip: _______________

I, the undersigned, authorize and request the Eastern Iowa Brain & Spine Surgery, PLLC (aka Practice) to:

Check One: [ ] Release To; [ ] Obtain From

Person/Organization: ___________________________________________________________

Address: ______________________________________________________________________

City: _________________________ State: _____ Zip: _______________

Phone: _______________________ FAX: _________________________

The following information from my medical records for care/treatment that I received from:

Name: ______________________________, from: ___________ until discharge or through ____________.

Check One: [ ] Any/all, or as much information as the releasing healthcare provider, in its sole discretion, deems reasonably necessary for the purposes set forth by me for release.

[ ] Specific Exclusions: ______________________________________________________

Purpose for Disclosure: _____________________________________________________________

This authorization is effective for _______________ or no longer than 1 year from the date on which it is 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 Chief Privacy Officer at Practice. A photocopy or facsimile of this release shall have the same effect as an original. I understand I have the right to inspect the information to be disclosed, and include my written statement about the record, upon proper notification to and under appropriate conditions established by the Practice. I acknowledge that the information to be released may include material that is protected by State and Federal Law applicable to either mental health, and/or drug and/or alcohol abuse and/or HIV/AIDS, and my signature authorizes release of such information, unless exceptions have been stated above.

Initials: __________

| Signature of patient or Representative | Date | Relationship to Patient | Witness | Date |
|---|---|---|---|---|
| ______________________________ | ________ | __________________ | ______________________ | ________ |

***(A copy of this signed form must accompany released information.)***

Release Processed (Initials): __________ Date: ______________

**PROHIBITION FOR RE-DISCLOSURE**: This information has been disclosed to you from records whose confidentiality is protected by Federal and/or State Law. The Authorization for Release of Medical Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, and State Law for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such laws and/or regulations. A general authorization for the release of medical information is NOT sufficient for these purposes. Civil and Criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/SIDS information.