CONSENT TO RELEASE MEDICAL INFORMATION

PATIENT_____
(Please print)

DATE OF BIRTH_____

I hereby request that my medical records be released from: Iowa Radiology
12368 Stratford Drive
Clive, Iowa 50325

Please send my records to: (Physician, hospital, or facility name) Initial

Doctor/ Facility: _____

Phone: _____

Fax: _____

Address: _____

Information Requested	**Date of Service**
___☐___**Films/CD**	_____
___☐___**Reports**	_____

This authorization will expire one year from the date of signature, except as specified

_____
Specify # of days or months

At this time, no express revocation shall be deemed to terminate my consent, but I understand that I may revoke this authorization at any time by sending a written notice to Iowa Radiology 12368 Stratford Drive, Clive, Iowa 50325. I understand that any release, which was made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting Iowa Radiology.

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Relationship (if not patient) Witness

_____

Specific Authorization for Release of Information Protected by State or federal law

I specifically authorize the release of data and information relating to: Check the appropriate box

1. Substance Abuse (Alcohol/drug abuse) ☐
2. Mental Health (includes psychological testing) ☐
3. HIV related information (AIDS related testing) ☐

SIGNATURE_____ DATE_____ *

For the above information to be released, you must sign here & check the appropriate box.