town square
FAMILY FOOT CARE
501 12th Avenue, Suite 203
Coralville, IA 52241

Date Received: _____
Date Processed: _____
Processed by: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:** _____

Address:_____ **City/State/Zip:** _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Physician/Medical Office:_____

Street/Suite:_____ **Telephone:**_____

City/State/Zip:_____ **Fax:**_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ☐ Check here to not release this information

This information may be disclosed and used by the following individual or organization:

Release To: _____

Street/Suite: _____

City/State/Zip: _____

Fax:_____ **Phone:** _____

Dates and Type of info to disclose:
☐ Complete Medical Record
☐ Specific Records/Dates Only:
_____

Purpose of Disclosure (required):
_____

Please deliver via: ☐ **FAX** ☐ **MAIL** ☐ **ELECTRONICALLY** (contact phone for setup:_____)

I understand that I have a right to revoke this authorization at any time in writing to the Healthcare Provider releasing my records. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative* **Date**

Complete if signed by someone other than the patient

_____ _____
Printed name of authorized representative Relationship / Capacity to patient

_____
Address and telephone number of authorized representative

*Guardian or Authorized Representative **must** attach documentation of such status

NOTE: Photocopy of this signed authorization shall be as effective as the original.