DORAN CLINIC FOR WOMEN

1015 Duff Avenue Ames, IA 50010
P: 515-239-6970 F: 515-239-6950

Medical Record #_____

Authorization for Release of Information

Patient Name: _____
Last First MI Other Name

Date of Birth: _____ Day Phone #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize (Print name/address of provider):

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

To release information from my medical record to:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax: _____

INFORMATION TO BE RELEASED: _____
_____

**The information disclosed may contain information regarding Substance abuse (including alcohol/drug use), Mental health (including psychotherapy notes) and/or HIC related information (AIDS related testing). If you DO NOT wish this information to be released, state here the information to be excluded: _____

I am requesting this information to be released for the following purpose:
_____Medical Treatment _____Transfer of Care _____Worker's Compensation _____Insurance
_____Disability _____At My Request _____Legal _____Moving _____Other

1. This authorization will automatically expire one year from date of signature or until _____.
2. 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 been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. By authorizing this release of information, my healthcare and payment for healthcare will not be affected if I do not sign this form. I may request to inspect or obtain a copy of the information described on this form. If requested, a copy of this release form will be provided to me.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ **OR** _____
Signature of Patient **Date** **Parent/Legal Guardian/Authorized Person** **Date**

_____ **OR** _____
Records Received By **Date** **Relationship to Patient** **Date**

For Office Use Only
Date Request Filled: _____ **By:** _____