

OB/GYN Associates of Des Moines, PLC
330 Laurel St. #1100
Des Moines, IA 50314

Phone: (515) 288-3287
FAX: (515) 334-7382

Authorization for Release of Protected Health Information

Patient Identification

Printed Name: _____
Address: _____

Date of Birth: _____
SSN: _____
Phone: _____

*****There is a \$15.00 for copying records. There is no charge if there are records being released to another medical provider. Payment must be received prior to release of records*****

Information is to be released by:

Information to be sent to:

(Physician or Facility)

(Street Address)

(City, State, and Zip Code)

(Telephone and Fax Number)

(Physician or Facility)

(Street Address)

(City, State, and Zip Code)

(Telephone and Fax Number)

Information to Be Released – Covering the periods Of Health Care

From (date) _____ to (date) _____

Please check the type of Information to be Released

<input type="checkbox"/> Complete Health Record	<input type="checkbox"/> Pap Smear Results	<input type="checkbox"/> OB Flow Sheets
<input type="checkbox"/> Lab Results	<input type="checkbox"/> X-Ray Results	<input type="checkbox"/> Other

Purpose of Request

<input type="checkbox"/> To update my regular doctor	<input type="checkbox"/> Referred to another doctor	<input type="checkbox"/> Billing or Claims
<input type="checkbox"/> Transferring care (May we contact you? _____)	<input type="checkbox"/> Moving- New Address: _____	

Please initial beside any category you DO NOT want to be released.

____ Substance abuse (drug or alcohol) ____ Genetics ____ Mental Health ____ HIV/AIDS Related (Diagnosis and Results)

Time Limit and Right to Revoke Authorization

This authorization will expire 90 days from the date which it was signed unless I specify a different time period. Expiration date or Event: _____. I understand that I may revoke this authorization at any time by giving written notice to OB/GYN Associates of Des Moines. A revocation of this agreement will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

Re-Release

I understand the information released pursuant to this authorization may be subject to re-release by the recipient and no longer protected by HIPAA.

Signature of Patient or Personal Representative Who May Request Disclosure

Your provider will not condition treatment, payment, enrollment or eligibility of benefits on your signing this authorization. You may inspect or copy your protected health information. By signing below, you authorize your provider, identified above, to release your protected health information specified above.

Signature or Legal Representative: _____ Date: _____

If Legal Representative, authority of Legal Representative: _____

(such as a parent of minor, court-appointed guardian, administrator of estate deceased or healthcare proxy)

Clinic Use Only

Reviewed and Approved by: _____

Records Sent: _____