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: _____ Date of Birth: _____

Address: _____ 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:

_____
(Physician or Facility)

_____
(Street Address)

_____
(City, State, and Zip Code)

_____
(Telephone and Fax Number)

Information to be sent to:

_____
(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

☐ Complete Health Record	☐ Pap Smear Results	☐ OB Flow Sheets
☐ Lab Results	☐ X-Ray Results	☐ Other_____

Purpose of Request

☐ To update my regular doctor	☐ Referred to another doctor	☐ Billing or Claims
☐ Transferring care (May we contact you? _____)	☐ Moving- New Address: _____	☐ FMLA/STD

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: _____