

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:**

**Information to be sent to:**

\_\_\_\_\_  
(Physician or Facility)

\_\_\_\_\_  
(Physician or Facility)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, and Zip Code)

\_\_\_\_\_  
(City, State, and Zip Code)

\_\_\_\_\_  
(Telephone and Fax Number)

\_\_\_\_\_  
(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: \_\_\_\_\_