BURGESS Health Center

Health Information Department
1600 Diamond St. - Onawa, IA 51040
PH: 712-423-9202
FX: 712-423-9341

REQUEST AND CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient _____ **Date of Birth** _____
Address: _____ Med Rec# _____
_____ Phone _____

I hereby authorize and direct _____ to furnish
to _____ phone _____
at _____ fax _____

the following information from my medical record (please check type of record below)

	Type of Record Requested	Date		Type of Record Requested	Date
	Hospital Inpatient			Outpatient/Clinic	
	Emergency Services			Skilled Nursing/ICF	

I authorize the following information to be released (please check)

	Complete Record		Radiology Reports
	History & Physical Exam		Consultation Report
	Emergency Room/Outpatient Services		Progress Notes
	Operative Report		EKG/EEG Interpretations
	Immunizations		Discharge Summary or Final Diagnosis
	Lab/Pathology Reports		Physical, Occupational or Speech Therapy
	Only the information deemed necessary as stated in the purpose for release.		Other (please describe)

The Information being disclosed may be used only for the following purposes *(please specify)*

☐ Payment or Reimbursement ☐ Utilization Review ☐ Continuation of Care

☐ Other-specified here _____

Information furnished in the form of (please circle one) Copies Mail Fax Telephone

I understand that this authorization is effective for 90 days from the date it is signed or _____ days, which ever is longer. I understand that I may revoke this authorization at any time except to the extent that actions have already been taken in reliance upon it, by giving notice to the Health Information Department. I understand that I have the right to inspect the information disclosed upon proper notification and under appropriate conditions established by Burgess Health Center.

Specific Authorization for Release of Information Protected by State of Federal Law

I specifically authorize the release of this Information as indicated by my initials OR if N/A

Type of Information to be Released	Initials of Patient or Legal Representative	Date
Alcohol/Drug Abuse Diagnosis/Treatment		
Mental Health Diagnosis/Treatment		
AIDS Related Diagnosis/Treatment/HIV Test Results		

_____ _____
Signature of Patient or Legally Authorized Representative Relationship to Patient

_____ _____
Date of Authorization Witness

_____ _____
Address if different than above Second Witness for Verbal/Phone Auth.

This information has been disclosed to you from records whose confidentiality is protected by State laws. State law prohibits you from making further disclosure of the Information without specific written consent of the person to whom the record pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.