

Burgess Family Clinic - Decatur  
823 S. Broadway #120 - Decatur, NE 68020  
PH: 402.349.5592 - FX: 712.423.9403

Burgess Family Clinic - Dunlap  
612 Iowa Ave. - Dunlap, IA 51529  
PH: 712.643.5880 - FX: 712.423.9404

Burgess Family Clinic - Mapleton  
513 S. Muckey St. - Mapleton, IA 51034  
PH: 712.882.2234 - FX: 712.423.9402

Burgess Family Clinic - Sloan  
409 Evans St. - Sloan IA 51055  
PH: 712.428.4100 - FX: 712.423.9401

Burgess Clinic - Whiting  
153 Blair St. - Whiting, IA 51063  
PH: 712.455.2431 - FX: 712.423.9408

## REQUEST AND CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Med Rec# \_\_\_\_\_  
Address: \_\_\_\_\_ Phone \_\_\_\_\_

I hereby authorize and direct \_\_\_\_\_ to furnish  
to \_\_\_\_\_ phone \_\_\_\_\_  
at \_\_\_\_\_ fax \_\_\_\_\_

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

<input type="checkbox"/> Complete Record	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Consultation Report
<input type="checkbox"/> Emergency Room/Outpatient Services	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Operative Report	<input type="checkbox"/> EKG/EEG Interpretations
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Discharge Summary or Final Diagnosis
<input type="checkbox"/> Lab/Pathology Reports	<input type="checkbox"/> Physical, Occupational or Speech Therapy
<input type="checkbox"/> Only the information deemed necessary as stated in the purpose for release.	<input type="checkbox"/> 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 \_\_\_\_\_

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

### 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		

I understand that this authorization is effective for 90 days from the date it is signed or \_\_\_\_\_ days, whichever 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.

**Please Read - Fee Information:** Burgess Family Clinic contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the medical record state fee structure as outlined in the state statute. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you agree to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to the patient, we may transfer a minimal portion of your records as a courtesy.

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.

Rev: 01/17