☐ 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)

	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 _____
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