

# Authorization for Release of Medical Records

Patient's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

I hereby authorize: \_\_\_\_\_

(Insert name of Physician, Hospital, Clinic, etc.)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

To disclose and deliver to: **Barbara L. Patrick, MD (dba as Woman to Woman Gynecology Services)** located at **2055 Oakdale Road, Suite C, Coralville, Iowa 52241. Phone 319-337-4900 Fax 319-337-5005**

*All medical information related to the patient listed above. I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and/or AIDS related information. I **SPECIFICALLY AUTHORIZE** the release of confidential information relating:*

Place "YES" or "NO" in **ALL** applicable boxes:

\_\_\_\_\_ Substance Abuse

\_\_\_\_\_ Mental Health Information

\_\_\_\_\_ AIDS-related Information

*This release does not authorize any re-disclosure of medical information except as indicated above. The recipient of this information is prohibited from using the information for other than the stated purpose and from disclosing it to any other party without additional authorization.*

*I understand that this authorization will automatically expire one year from the date of my signature and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.*

**I authorize the release of the information as indicated above:**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date