Keokuk County
Medical Clinic

(641) 622-1170 | **Fax** (641-903-7024)
1314 South Stuart Street, Suite B | Sigourney, Iowa 52591
www.keokukhealth.com

Authorization to Release Patient Information

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient. This authorization may be revoked by the patient at any time.

Patient Legal Name ______________________________ Date of Birth _____ / _____ /______

Patient Address ______________________________ Phone (________) ________________

I, ______________________________

hereby authorize ______________________________

to release medical information via copies, viewing or verbal to ______________________________

______________________________.

Check the information to be disclosed:

☐ All Records or specify (include dates if necessary) ______________________________

☐ Allergy List
☐ Billing Information
☐ Consult Reports
☐ Discharge Summary
☐ History and Physical
☐ Immunization Record
☐ Laboratory Results
☐ Medication List
☐ Problem List
☐ X-Ray and Imaging Reports
☐ Other, specify ______________________________

I understand that information to be released may contain information in the following categories unless I specifically deny the release. Initial any category you DO NOT want released:

__________ Substance Abuse (Drug/Alcohol abuse & testing)

__________ Mental Health/Depression (includes psychological testing)

__________ HIV-Related information (AIDS related testing)

Please provide reason for release:

☐ At the Request of the Individual
☐ 2nd Opinion
☐ Insurance
☐ Legal
☐ Moving out of area
☐ Other Medical Care
☐ Transfer of Care
☐ Other ______________________________

Affirmation of Release

I give ______________________________ or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to the expiration date stated below or a maximum of one year and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient, I have the right to access my treatment records. Copies of records may be obtained with reasonable notice and payment of copying costs. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health clearinghouse covered by the federal privacy regulation or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

Patient Legal Name ______________________________

Signature of Patient ______________________________

Representative and Relationship if applicable ______________________________

Date signed ______________________________

Expiration date ______________________________