Physicians Clinic of Iowa, PC
Fax#: (877) 671-3861
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Questions? Contact HealthMark Group
Call: (800) 659-4035
Email: status@healthmark-group.com

MEDICAL RECORDS AUTHORIZATION

Patient's Name:	Date of Birth:
Address:	City, ST, Zip:
Phone:	Email:

PLEASE RELEASE THE INFORMATION BY THIS METHOD: (Select 1 option only)

☐ **Secure Email** (provide Email here):

☐ **Fax** provide Fax number here):

☐ **Mail**

RELEASE THE INFORMATION FROM:

Physician/Practice:

Address:

City, ST:

Phone:

RELEASE THE INFORMATION TO:

Physician/Practice:

Address:

City, ST:

Phone:

PROVIDE DATES OF SERVICE

☐ Provide Records from(m/d/y) _____through_____

☐ Records for all dates of service

PURPOSE FOR RELEASE

☐ Continuing Care
☐ Transfer of Care
☐ Disability
☐ Legal/Attorney
☐ Insurance
☐ Other:

RECORDS TO BE RELEASED (45 CFR § 164.508(c)

☐ Office Notes
☐ Lab Reports
☐ Operative Reports
☐ X-Ray Reports
☐ CD of Images done at PCI
☐ Additional Information:

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire 180 days from the date of my signature unless I revoke the authorization prior to that time.

Signature: _____ **Date:** _____

Reason if patient is unable to sign: _____
(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)