1003 Grand Avenue • West Des Moines, IA 50265 • (515) 267-1003 • Fax (515) 267-0100

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ Date of birth _____

Last 4 digits of soc sec # _____ Daytime phone # _____

Any previous names under which records may be kept _____

I, the undersigned, voluntarily authorize and request **KAVALIER & ASSOCIATES, P.C.** to: ☐ release to ☐ obtain from

Person/organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I authorize the release of records dating from _____ to _____

☐ Any/all or as much information, written or verbal, as the releasing healthcare provider, in its sole discretion, deems reasonably necessary for the purposes set forth by me for release.

☐ Specific Exclusions _____

I specifically authorize the release of protected confidential information regarding:

☐ Mental Health ☐ Drugs or Alcohol ☐ HIV/AIDS

The purpose of this release is:

☐ Coordination of Care ☐ Treatment Planning ☐ Transfer of Care ☐ Referral for services

☐ Educational Planning ☐ Discussion/coordination with family members ☐ Personal Use

☐ Legal Use ☐ Billing/Payment ☐ Other _____

This authorization is effective for one year from the date it is signed. A photocopy or facsimile of this release shall have the same effect as an original. I understand I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Kavalier & Associates, P.C. I understand I have the right to inspect the information to be disclosed, upon the proper notification to and under appropriate conditions established by Kavalier & Associates, P.C. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal regulations. I understand my healthcare and payment for my healthcare will not be affected by this authorization.

PROHIBITION OF REDISCLOSURE

This form does not authorize the redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records and HIV/AIDS test results, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch. 228 & ch 141) prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug or mental health related information or HIV/AIDS test results.

I acknowledge that the information to be released may include material that is protected by State and Federal Law applicable to either mental health, and/or drug and /or alcohol abuse and/or HIV/AIDS, and my signature authorizes release of all such information unless exceptions have been stated above

_____ *(Signature of Patient or Authorized Representative)* *Date*

_____ *(Relationship to Patient)*

_____ *(Witness)* *Date*

A copy of this authorization must accompany released information.

Request Processed: (Initials) _____ Date _____

White - Medical Record

Yellow - Patient Copy

There may be a charge associated with the copying of medical records.