Authorization for Release of Medical Information

Patient's Name	Maiden Name, if applicable
Address	Date of Birth
City, State and Zip Code	Telephone Number

Provider/Organization authorized to release the information: _____

Phone: _____ Fax: _____

Requestor: Sioux Valley Family Health
115 E Maple St
Cherokee, IA 51012
Phone: 712-225-9003
Fax: 712-225-9004
Email: svfhbrandie@gmail.com

Information Requested: ☐ Entire Record ☐ Lab/Xray Results ☐ ER Report ☐ H&P ☐ Discharge Summary
☐ Other: _____

Purpose of Release: ☐ Transfer of Care ☐ Continuation of Care ☐ Legal ☐ SSA/Disability ☐ Personal Use
☐ Other: _____

I authorize the release of the information listed below, which requires specific consent under federal law (check all that apply): ☐ Substance Abuse ☐ Mental Health Treatment ☐ HIV/AIDS related testing ☐ social service records

For mental health, alcohol and/or drug abuse patient records, I understand that my records are protected under federal regulations governing confidentiality, including Alcohol and Drug Abuse Patient Records (42 CFR Volume 1, Chapter 1, Part 2) and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I understand that this communication will reveal my presence as a patient at this treatment facility.

Patient/Authorized Representative:_____ Relationship: _____

This authorization is effective for __ months but no longer than 1 year from the date on which it was signed. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it.
I agree to indemnify and hold SVFH clinic, its employees and agents free and harmless from any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information. I have read this consent entitled "Authorization for Release of Medical Information" and I hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.
I understand that, once my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure or release by the receiving party and may no longer be protected by state or federal law.
I understand that my continued or future treatment by Sioux Valley Family Health, payment, enrollment in a health plan or eligibility for benefits is not conditional upon my providing or signing this authorization.

Patient/Authorized Representative:_____ Relationship: _____

Witness: _____ Date: _____