Lakeview Surgery Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____Birth Date _____

Soc. Sec Num _____ Phone (home) _____ (work)_____

Address _____

City _____ State _____ Zip _____

I, the undersigned, do authorize and request Lakeview Surgery Center to release information from my (the patient's) medical records to:

Person/Organization (print) _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _ _____

I agree that Lakeview Surgery Center may release information from _____ to _____

concerning the following medical records:

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

☐ Complete Medical Record

☐ Other (please specify) _____

This information is being disclosed and may be used only for the following purpose(s) _____

_____

Specific Authorization for Release of Information Protected by State or Federal Law

I specifically authorize the release of data and information relating to: (check appropriate boxes)

❒ Mental Health Treatment ❒ Drug or Alcohol Abuse Treatment ❒ HIV/AIDS test results

*_____

*In order for this information to be released, you must sign here and below, check the appropriate box(es).

This authorization if effective for _____ months but no longer than one year from the date on which it is signed. I understand that 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 the Director of Medical Records, at Lakeview Surgery Center, 1750 60th Street, West Des Moines, Iowa 50266-5733.

I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Lakeview Surgery Center. I understand that LSC will not condition my treatment on whether I provide authorization for the requested use or disclosure.

PROHIBITION OF REDISCLOSURE

This form does not authorize 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 lay for mental health records, and HIV/AIDS test result, federal requirements (42 CFR Part 2) and without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization form 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 abuse or mental health related information or HIV/AIDS test results. I further understand that if the person or entity that received the above specified information is not a health care provider, health plan or health care clearing house covered by the federal privacy regulations or a business associate of the entities, the information described above may be redisclosed an no longer protected by the regulations.

_____
Signature of Patient or Patient's Authorized Representative

_____
Relationship of Authorized Representative

_____
Date