Lakeview Surgery Center

Patient's Name:(print) _____ Birth Date: _____

Soc. Sec. No: _____ 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 Person/

Organization (print) Address: _____

City: _____State:_____ Zip:_____

Phone:_____Fax:_____

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

date date

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 box(es)

❒ 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, and check the appropriate box(es).

This authorization is 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.

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 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 Relationship of Authorized Representative & ch. 141) prohibit further disclosure without the 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 abuse or mental health related information or HIV/AIDS test results.

_____

Signature of Patient or Patient's Authorized Representative

_____

Date

Office Use Only __Date Information Sent _____By__ _____Department__ _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION