

SMCH  
1301 W. Main  
Lake City, IA 51449  
712-464-3171  
Fax: 712-464-1108

Stewart Memorial Gowrie Clinic  
1800 W. Main St.  
Gowrie, IA 50543  
712-464-8891

Stewart Memorial Lake City Clinic  
1351 W. Main  
Lake City, IA 51449  
712-464-7907

Stewart Memorial Lake View Clinic  
1160 3<sup>rd</sup> St.  
Lake View, IA 51450  
712-665-8555

Stewart Memorial Rockwell City Clinic  
505 E. Lake St.  
Rockwell City, IA 50579  
712-297-8989

## Authorization for Release of Medical Information

**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 at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Medical Records Department of the source facility. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the source facility. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to redisclosure. I understand that I am entitled to receive a copy of this completed authorization form.**

<b>INSTRUCTIONS:</b>	<i>Make sure all blanks are filled in. Failure to do so could prevent or delay processing.</i>
<b>PATIENT IDENTIFICATION</b>	Name (last, first, middle initial): _____ Date of Birth: _____ Last 4 digits of Soc. Sec.#: _____ Any previous names under which records may be kept: _____ Telephone number where we can reach you if we have questions: _____
<b>PROVIDER</b> (Who is to disclose the information?)	<input type="checkbox"/> SMCH <input type="checkbox"/> Stewart Memorial Clinics <input type="checkbox"/> SMC MR Behavioral Health <input type="checkbox"/> Other entity (please specify): _____ Street address: _____ City, State and Zip: _____
<b>RECIPIENT</b> (Who is to receive the information?)	Name: _____ Street address: _____ City, State and Zip: _____ Telephone number: _____ Fax number (if applicable): _____
<b>PURPOSE OF RELEASE:</b>	<b>(Check all that apply)</b> <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance Coverage <input type="checkbox"/> Legal <input type="checkbox"/> SSA/Disability <input type="checkbox"/> Personal Use <input type="checkbox"/> Other _____
<b>Requested Format:</b>	<input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Other _____
<b>Information</b> (What information should be released?)	<b>(Check all that apply)</b> <input type="checkbox"/> Records dating from: _____ to: _____ <input type="checkbox"/> Provider Notes <input type="checkbox"/> Emergency Room Record <input type="checkbox"/> Complete Record <input type="checkbox"/> Lab Reports <input type="checkbox"/> X-ray Reports / <input type="checkbox"/> Images <input type="checkbox"/> Billing Statement <input type="checkbox"/> Other: _____

### SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I authorize the release of the information listed below, which requires specific consent under federal law: **(check all that apply)**  
**(Note: Depending on what is checked we may be unable to fulfill this authorization.)**

Substance Abuse                       Mental Health Treatment (excluding psychotherapy notes)                       HIV/AIDS related testing

Signature of Patient or Authorized Representative: X \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature of patient or legal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient, if signed by legal representative: \_\_\_\_\_

#### 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 and HIV/AIDS records, federal requirements (42 C.F.R., Part 2) and state requirements (Iowa Codes Chapters 228 and 141.23) prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by law 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, mental health or HIV/AIDS-related information.

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_