SURGICAL ASSOCIATES, LLP
GRINNELL

122 4th Avenue, Grinnell IA 50112 Phone: 641-236-4323 Fax: 641-236-0680

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient name:_____ Date of Birth _____ Social Security (last 4):_____

By signing this form, I authorize _____
to release/obtain healthcare information of the patient named above to:

Name: _____

Address:_____

City:_____ State: _____ Zip code: _____

Phone:_____ Fax:_____

This release and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Specific dates to be included in release:_____ (if not specified, last 2 years will be sent)

Specific Authorization for Release of Information Protected by State or Federal Law
I specifically give permission to release/obtain data and information relating to the following:

☐Mental Health ☐ Substance Abuse ☐ HIV/AIDS (related information

_____ _____
Signature of Patient or Legal Guardian Date

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

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to Surgical Associates at the address listed above. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) I understand that once the information is disclosed, the recipient may re-disclose the information, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Surgical Associates, LLP.

Signature of Patient or Legal Guardian:_____ Date:_____

Relationship, if not patient: _____

For Surgical Associates use only

☐ *Faxed* ☐ *Emailed* ☐ *Mailed* *Date:*_____ *Initials:*_____