CONSENT TO RELEASE/AUTHORIZATION TO OBTAIN INFORMATION

Patient Name _____ **Date of Birth:** _____

I, the undersigned, do authorize and request _____ to release to

_____ my medical records for care and treatment that I received

from _____ to _____ **OR** ☐ all dates of records

Check the information to be disclosed (include dates where indicated):
☐ Minimum necessary or specify:

☐ Medication list ☐ Allergy list ☐ Immunization record

☐ Problem List (Pt. Summary list)

☐ Most recent history and physical or specific date _____

☐ Most recent discharge summary or specific date _____

☐ Laboratory results, specify type or date _____

☐ X-ray and imaging reports, specify type or date _____

☐ Consultation reports (specify doctor or clinic) _____

☐ Test results (i.e. EKG, PFT, etc.), specify type and date _____

☐ Billing Information, specify _____

☐ Other, specify _____

☐ Any and All

The form in which the information is to be released: ☐ Written ☐ Fax ☐ Electronic ☐ Other:_____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to:
Stadia Sports Medicine, 6000 University Avenue Suite 250, West Des Moines, IA 50266

I understand that any release, which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and 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 the Administrative contact at the above address.

I understand that Stadia Sports Medicine may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release. (***initial*** any category ***not*** to be released). Substance Abuse _____ Mental Health _____ HIV-related information_____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____.

Signature of Patient or Legal Guardian **Date**

_____

Witness Signature **Date**

_____

Return this form via fax 515-221-1272, mail to the above address or via email to reception@stadiasportsmedicine.com (IMPORTANT. By choosing to use email communication with us, you must agree to the following: Email is an open network, which provides no protection for the confidential exchange of health-related information.