AUTHORIZATION TO RELEASE INFORMATION
Medical Associates Clinic, P.C. & Affiliated Entities

Release of Information: 1500 Associates Drive, Dubuque, IA 52002
Telephone 563-584-3207; FAX 563-584-3216
(Important: PRINT information)

Patient's Full Name_____ History #_____

Previous Name/s (if any)_____ Date of Birth_____

Address_____

Daytime Phone_____ Last 4 Digits of Social #_____

Records Released From:

Name (i.e. health facility, physician, ...)

Street Address

City State Zip Code

Phone # Fax #

Records Released To:

Name (i.e. health facility, physician, ...)

Street Address

City State Zip Code

Phone # Fax #

Indicate the information to be released or received on: ☐ Paper ☐ CD

☐ Immunizations ☐ Billing and payment information (Business Office)
☐ Most recent 2 years of medical records, including lab and x-ray, unless otherwise specified
☐ Other (Specify here if you only need notes from one MD or Department or only lab or x-ray results, or ADHD, or other specifics):

_____

_____

Please check the reason for release and provide a date by which the information is needed:_____

☐ Coordination of care ☐ Transfer of care ☐ 2nd Opinion ☐ Legal ☐ Insurance Application

☐ Insurance Claim ☐ Other _____

This information released may include matters regarding **mental health** (including psychotherapy notes, and/or ADHD, and/or autism), **alcohol or drug abuse**, and **infectious diseases** (including AIDS/HIV-related information, diagnosis, and test results). Refusal to consent to release of information will result in such confidential records not being released.

IF YOU DO NOT WISH SUCH INFORMATION RELEASED, STATE INFORMATION TO BE EXCLUDED:_____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Manager of Release of Information, Medical Associates Clinic, P.C., 1500 Associates Drive, Dubuque, IA 52002. 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) recipients of this information may possibly re-release the information without proper authorization, 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 the Manager of Release of Information at the above address. Medical Associates does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services. A photocopy of exact reproduction of this signed authorization shall have the same force and effect as the original.

This agreement will expire two years from the date of signature, but in no case valid for more than two years, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

Signature of Patient or Legal Guardian Printed Name Date

Relationship to patient (Parent, Guardian, Health Care POA, etc.) _____

I have ☐ accepted ☐ declined a copy of this Release of Information. _____ (initials)

PROCESSING OF AUTHORIZATIONS MAY REQUIRE 30 DAYS FROM DATE RECEIVED AT MEDICAL ASSOCIATES CLINIC, P.C.

For MAC Staff Use:
Staff/Dept. Assisting Patient _____
Name Dept. Date Ext. #

☐ To ROI for Processing
(FCNs fax form to: 584-3216; All others interoffice mail)

☐ To Medical Records for Scanning (Processing Complete)
(Interoffice to Medical Records)