North Liberty Family Health Centre
420 Community Drive Suite 1
North Liberty, IA 52317
(319) 626-6006
Fax (319) 626-3400

Please PRINT (except signatures) and provide complete answers and addresses in each section.

PATIENT: Name: _____
Address: _____
_____
_____ _____
Date of Birth SS#

PROVIDER: Name: _____
(Who is Releasing the information?) Address: _____
_____

REQUESTOR: Name: _____
(Where do you want it sent?) Address: _____
_____

Check the information to be disclosed (include dates where indicated):
☐Complete Medical Records _____
☐Laboratory Results, specify types and date(s) _____
☐X-ray and imaging reports, specify types and date(s) _____
☐Test results (i.e., EKG, PFT, etc.), specify and date _____
☐Billing information (copies of billing statements) _____
☐Other, specify _____
As per my request, reason for release of information:
☐ medical care ☐ legal ☐insurance ☐ other (specify) _____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to North Liberty Family Health Centre, 420 Community Dr. Ste. 1, North Liberty, IA 52317. I understand that any release that 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 Practice Administrator of the North Liberty Family Health Centre at the address listed above.

I understand that North Liberty Family Health Centre 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 form the date of signature, unless previously revoked or otherwise indicated (specify number of days or months)_____

_____
Signature of Patient or Legal Guardian Date

_____
Complete Mailing Address/Street/PO Box City/State/Zip

_____ _____
Relationship, if NOT the patient Witness Signature