PHYSICIANS' CLINIC
of Iowa, P.C.
Together in health.

202 10th Street SE | Cedar Rapids, IA 52403
Phone: (319) 398-1596 | Fax: (319) 399-2048
www.pcofiowa.com

Physicians' Clinic of Iowa, PC
Medical Record Authorization

Patient Name: _____ Maiden Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ Email Address: _____

A) I hereby authorize records **FROM**:

PCI Provider/PCI Specialty: _____

Address: _____

City/State/Zip: _____

Phone _____ Fax: _____

B) To be released **TO**:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

C) For the Purpose of:

- ☐ Self/Personal Copy
- ☐ Insurance
- ☐ Transfer or Continuity of Care
- ☐ Disability
- ☐ Workers' Comp
- ☐ **Other:** _____

D) Dates of Service: __/__/__ to __/__/__

- ☐ Physician's Office Notes
- ☐ Operative/Procedure Report
- ☐ Lab/Path Reports
- ☐ Xray Reports ☐ CD of Xray Images
- ☐ Other: _____

I understand that Physicians' Clinic of Iowa does not require this form as a condition of evaluation or treatment and that I have the right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Health Information Department, 202 10th Street SE, Cedar Rapids, IA 52403. I understand that my revocation will not apply to information that has already been released in response to this authorization.
I also understand that I have the right to view and/or receive copies of my health information and that there may be a charge for copies.
I understand that the information in my health record may include information relating to mental health, substance abuse, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human Immunodeficiency virus (HIV).
I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws. This authorization automatically expires in 1 year from date of the signature.

Signature of Patient /Legal Representative (specify relationship): _____
Date _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, AIDS-RELATED MEDICAL INFORMATION OR GENETIC-RELATED INFORMATION.

I acknowledge that information to be released may include material that is protected by Federal and/or state law applicable to substance abuse, mental health and/or AIDS-related information, and/or genetic-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to (Place "YES" or "NO" in all applicable boxes):
___ Substance Abuse (drug or alcohol) Information from: _____
___ Mental Health Information from: _____
___ AIDS-related Information, Diagnosis, and test results from:_____
___ Genetic testing, profiles, counseling, services, education and medical histories which focus on genetically related diseases or conditions information, diagnosis, and test results from: _____

Signature of Patient /Legal Representative (specify relationship): _____
Date _____