Floyd County Medical Center – Charles City, Iowa
Authorization to Release Patient Information

Medical Record #: _____

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below, or is revoked in writing. A copy of this signed form will be provided to the patient on request.

I hereby authorize [name of provider/address]: _____Floyd County Medical Center (FCMC) _____

To disclose the following information from the health records of:

Name: _____
Last First MI Previous Name

_____ H _____ W/C _____
Birth Date Social Security Number Home Telephone Numbers Work or Cell

Address: _____
Street City State ZIP

This information is to be disclosed to:

_____
(If another person/entity, include full address, fax number, or email.)

Covering the periods of healthcare (Date(s) of service): From: _____to_____

For the purpose of: _____
(Not required if the disclosure is requested by the patient.)

The following information may be released: Be specific on information requested. ☐ Electronic ☐ Paper

_____

Visit #: _____

I understand that this will include information relating to (check and initial if applicable):

_____ ☐ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
_____ ☐ Behavioral health service/psychiatric care
_____ ☐ Treatment and/or assessment for alcohol and/or drug abuse

_____ I do authorize transmission of my medical information by FAX machine.

_____ I do authorize release of information from another facility/provider found in my record

_____ I authorize transmission of my medical record by email. I understand that even when encrypted, emailed information could be read by a third party and FCMC cannot guarantee secure delivery.

Affirmation of Release

I give __ FCMC_____ or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not effect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient, I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan health care clearing house covered by the federal privacy regulations, or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

_____ _____
Signature of Patient/Guardian/Legal Representative Date Signed

_____ _____ ☐ Information sent?
Signature of Witness Date Signed

Expiration Date: One year from date signed or by giving other specific written notice to the healthcare provider. This authorization can be revoked by written request.

RELEASE

Release # _____ Date: _____