Authorization for Release of Medical Records

Patient's Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____

I Hereby Authorize: _____

(Name of Physician, Hospital, Clinic, etc)

Address: _____

City: _____ State: _____ Zip Code: _____

To Disclose and Deliver to:

Margaret A. Smollen, M.D., P.C.
Located at: 319 East Bloomington St. Iowa City, IA. 52245
Phone: 319-887-2229 Fax: 319-887-0906

All Medical Information Related to the Patient Listed Above

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. **I SPECIFICALLY AUTHORIZE the release of confidential information relating to:**

Please place "**YES**" **or** "**NO**" in **ALL** applicable boxes:

_____ Substance Abuse

_____ Mental Health Information

_____ AIDS-Related Information

This release does not authorize any re-disclosure of medical information except as indicated above. The recipient of this information is prohibited from using the information for other than the stated purpose and from disclosing it to any other party without additional authorization.

I understand that this authorization will automatically expire one year from the date of my signature and that I may revoke this authorization by sending a written noticed to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of the information as indicated above:

_____ _____

Patient/Guardian Signature **Date: MM/DD/YEAR**