Dubuque ENT

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HEAD & NECK SURGERY PC
Advanced, personal care from our family to yours
535 Cedar Cross Road, Dubuque, IA 52003
(563)588-0506 or (800)848-7507
Online: www.DubuqueENT.com

Jenny Hruska, Au.D.
Taylor Schaul, Au.D.

CONSENT TO RELEASE MEDICAL INFORMATION:

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

Previous Names Used (if any): _____

The undersigned hereby authorizes Dubuque ENT Head and Neck Surgery, P.C., to:

( ) Release Records to: **( )** Request Records from:

Facility: _____

Phone Number: _____ Fax Number: _____

Provider: _____

Please fax all records to be received by Dubuque ENT Head & Neck Surgery, PC to 563-588-0451

Purpose of Release:

( ) Transfer ( ) Insurance ( ) Legal ( ) Continuity of Care ( ) Personal ( ) Other _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

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 related to (please circle yes or no for each category):

YES NO Substance abuse (drug or alcohol) information

YES NO Mental health information

YES NO Aids-related information, diagnosis and test results

For the above information to be released, you must sign here AND at the end of this form.

_____ _____ _____

Signature of Patient or Legal Guardian Date Relationship if NOT the patient

Federal and/or State law specifically require(s) that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health or AIDs-related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical records or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
See also chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

I authorize electronic transmission (fax/ secure email) of my medical records. This entire Authorization shall be effective upon signing and shall remain effective until revoked by me. No revocation of this Authorization shall be effective unless made in writing and delivered to Dubuque ENT Head and Neck Surgery, P.C.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as the original. I understand that I have the right to inspect the disclosed information upon request and at reasonable hours.

I hereby authorize the release of this information as indicated above.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship, if NOT the patient