Council Bluffs Surgical Associates, P.C.

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1. Patient Name: _____Date of Birth:_____

   Address:_____

   Telephone Number: (_____)_____Previous Name (if applicable):_____

2. I hereby authorize_____

   (Facility / Provider Name and Location)

   Release information from the medical records to: _____

   (Name / Address of Person or Organization to which disclosure is to be made)

   Fax #:(_____)_____ Telephone Number:(_____)_____

3. For treatment date:_____

   (Specify dates)

   - ☐ Records from last _____year(s), including progress notes, lab and x-rays.
   - ☐ Complete medical records including progress notes, lab and x-rays.
   - ☐ Lab Reports dates(s)_____.
   - ☐ X-ray reports dates(s)_____.
   - ☐ Progress Note date(s)_____.
   - ☐ Other _____

     _____

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

   I hereby specifically authorize the release of data and information relating to: (check any that apply)

   - ☐ HIV / AIDS related testing
   - ☐ Mental Health
   - ☐ Chemical Dependency (Drug/Alcohol)

5. Purpose of Release:
   - ☐ Medical Care
   - ☐ Transferring Care
   - ☐ Personal Records
   - ☐ Attorney
   - ☐ Insurance
   - ☐ Other (please explain)_____

This statement of consent can be revoked at any time before disclosure of the information, and expires on _____ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

_____ _____

(Signature of patient) *(Signature of parent, guardian, or authorized representative)*

_____ _____

(Date) *(Relationship of above person to patient)*