

Council Bluffs Surgical Associates, P.C.

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Patient Name: _____ Date of Birth: _____

Address: _____

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

Patient Number: _____

I hereby authorize _____
(Facility / Provider Name and Location)

To release information from the medical record of _____
(Patient Name)

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

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

For treatment dates: _____
(Specify dates)

<p>The following information:</p> <p><input type="checkbox"/> Records from last _____ year(s), including progress notes, lab and x-rays.</p> <p><input type="checkbox"/> complete medical record including progress notes, lab and x-rays.</p> <p><input type="checkbox"/> Lab Reports date(s) _____</p> <p><input type="checkbox"/> X-ray Reports date(s) _____</p> <p><input type="checkbox"/> Progress Note date(s) _____</p> <p><input type="checkbox"/> Other _____</p>	<p>For the following purpose:</p> <p><input type="checkbox"/> Legal</p> <p><input type="checkbox"/> Insurance</p> <p><input type="checkbox"/> Patient request</p> <p><input type="checkbox"/> Other (please explain) _____</p>
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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)

This authorization will be valid for 180 days from the date it is signed or until _____, whichever is shorter. this authorization may be revoked at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. MHS and its affiliates cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

Signature of Patient or Legal Guardian
(Parent/Legal guardian must sign if patient is a minor:
NE under age 19; IA under age 18)

Relationship to Patient, if not the Patient

Date:

OFFICE USE ONLY

Copied by: _____ Date: _____

To be sent

To be picked up Date: _____

Sent on Date: _____

Picked up on Date: _____

Released by: _____

Release to: _____