Linden Point Clinical Associates, P.C.
1441 29th Street, Suite #305
West Des Moines, IA 50266
Phone: (515) 985-2024
Fax: (515) 985-2025

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient name: ____ Date of Birth:_____________
Address: ____
Any previous names under which the records may be kept: ____

I, the undersigned, voluntarily authorize and request, *Linden Point Clinical Associates, P.C.* to: ☐ Release to ☐ Obtain from
Person/Organization:____
Address: _______________________________________City/State:______________________ Zip:_________
Phone: ____ Fax: ____
Email Address:____

I authorize the release of records dating from_____________________ to _________________________

☐ Any/all or as much information, written or verbal, as the releasing healthcare provider, it its sole discretion, deems reasonably necessary for the purposes set forth by me for release.

☐ Specific Exclusions:____

I specifically authorize the release of protected confidential information regarding:
☐ Mental Health ☐ Drugs or Alcohol ☐ HIV/AIDS

The purpose of this release is:
☐ Coordination of Care ☐ Billing/Payment ☐ Transfer of Care ☐ Referral for Services
☐ Communication with Family Member ☐ Other ____________________

I understand that *Linden Point Clinical Associates, P.C.* cannot guarantee the confidentiality of information transmitted by fax or email. I authorize *Linden Point Clinical Associates P.C.* to transmit information via: ☐ Fax ☐ Email

This authorization is effective for one year from the date it is signed. I understand I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice in writing to *Linden Point Clinical Associates, P.C.* I understand I have the right to inspect the information to be disclosed, upon the proper notification to and under appropriate conditions established by *Linden Point Clinical Associates, P.C.*I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal regulations. I understand my healthcare and payment for my healthcare will not be affected by this authorization.

Prohibition of Redisclosure

This form does not authorize the redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records and HIV/AIDS test results, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch.228 & ch.141) prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug or mental health related information or HIV/AIDS test results.

I acknowledge that the information to be released may include material that is protected by state and federal law applicable to either mental health, and/or drug and/or alcohol abuse and/or HIV/AIDS, and my signature authorizes release of all such information unless exceptions have been state above.

____
(Signature of Patient or Authorized Representative) Date

____
(Relationship to Patient)

____
(Witness) Date