Linden Point Clinical Associates, P.C.
2545 106th Street
Urbandale, IA, 50322
Phone: (515) 985-2024
Fax: (515) 985-2025

Linden Point
— CLINICAL ASSOCIATES P.C. —

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, to 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 □ Substance Abuse □ 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 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 medication 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 of mental health records and HIV/AIDS test results, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch.228 & ch.131) 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 penalities may result for 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 stated above.

_____
Signature of Patient or Authorized Representative *Date*

_____
(Relationship to Patient)

_____
(Witness) *Date*