

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(Iowa Board of Medicine)

Patient Name: _____ . Date of Birth: _____ .
Social Security Number: _____ . Phone Number: _____ .
Address: _____ .
City: _____ . State: _____ . Zip Code: _____ .

I hereby authorize the release of my personally identifiable protected health information to the Iowa Board of Medicine (IBM) for use in a confidential investigation being conducted by the IBM. This authorization includes records of a public, private or confidential nature, including the following:

<input checked="" type="checkbox"/> Consultation	<input checked="" type="checkbox"/> History & Physical	<input checked="" type="checkbox"/> Operative Report
<input checked="" type="checkbox"/> Assessment/Evaluation	<input checked="" type="checkbox"/> Treatment Summary	<input checked="" type="checkbox"/> Social History
<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Lab, X-ray, EKG	<input checked="" type="checkbox"/> Pathology Report

I understand that I may revoke this release in writing at any time, except to the extent that the IBM has already taken action in reliance upon this release. I understand that this release shall remain valid for the duration of the IBM investigation unless revoked by me. I understand that I have a right to inspect the information to be disclosed upon proper notification to and under appropriate conditions as established by the IBM. I understand that my authorization is voluntary and that my health care will not be affected if I do not sign this form. I acknowledge that I have been provided a copy of this authorization.

SPECIFIC RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of protected health information relating to:

(Please check appropriate boxes)

Mental Health Drug and Alcohol Abuse Records HIV/AIDS Test Results

I have read and fully understand the contents of this "Authorization to Release Information."

Signature of Patient or Patient's Authorized Representative

Date

PROHIBITION ON REDISCLOSURE

This form does not authorize re-disclosure 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, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

A photocopy/reproduction of this authorization shall have the same force and effect as the original.