AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO CSPC

Patient's Name_____

Address_____
(Street, City, State, Zip Code)

Social Security Number: _____Date of Birth:_____

I, the undersigned, do authorize and request _____,

Address: _____Fax:_____
to release information or copies of my medical records for care and treatment that I received, as well as letters of consultation, hospital records, outpatient testing results and records from other physicians you may have regarding my medical history.

Information requested:

☐ Complete Records ☐ Labs - Date _____ ☐ Images - Date_____

☐ Other_____

Purpose: ☐ Specialist Visit ☐ Transferring Care ☐ Other_____

These should be released to:

CENTRAL STATES PAIN MEDICINE
2425 Westown Parkway
West Des Moines, Iowa 50266
PLEASE USE THIS AS A COVER SHEET AND FAX RECORDS TO: 515-457-9180

State and/or Federal regulations prohibit the disclosure of medical information regarding treatment of mental health or illness, drug or alcohol abuse and HIV testing without specific written consent of the patient, or as otherwise permitted by such law and/or regulations.

I specifically authorize the release of data and information relating to Substance Abuse, Mental Health, and HIV and or AIDS related testing if applicable.

This authorization is effective for no longer than one year from the date on which it is signed. I understand that 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 the holder of my records named above.

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 and state requirements which prohibit further disclosure without specific written consent of the patient, or 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 apply for unauthorized disclosure of alcohol/drug, mental health or HIV information.

_____
Signature of Patient or Patient's Authorized Representative Date

_____
Relationship of Authorized Representative

_____
Witness Signature Date

Req Prov. _____

If you have questions regarding this request, please contact our office at 515-267-1819