Please **PRINT** (except signatures) and provide complete answers in each section.

Patient Name_____ Birth Date_____Phone _____
I understand by signing this form, I am allowing _____ to release information concerning the above named patient to:

Name of Person and/or Institution:			
Complete mailing address: Street/PO Box	City	State	Zipcode

I wish to receive my medical records in the following format: ❑ paper ❑ CD

Check the information to be disclosed (include dates where indicated): ❑ Minimum necessary or specify:
❑ Medication list ❑ Allergy list ❑ Immunization record ❑ Problem List (Patient Summary List)
❑ Most recent history and physical or specific date(s) _____
❑ Most recent discharge summary or specific date(s) _____
❑ Laboratory results, specify types or dates _____
I understand that this information is strictly for my own knowledge regarding my laboratory testing, that I will not ask the laboratory staff to interpret my results, and that I should not make any changes to medication dosages or schedules without first consulting my medical provider about these specific test results. This authorization will expire upon receipt of the information requested.
❑ X-ray and imaging reports, specify types or dates _____
❑ Consultation reports from (doctors' names or clinic)_____
❑ Test results (i.e., EKG, PFT, etc.), specify type and date _____
❑ Billing info _____
❑ Other, specify: _____

The reason for release of information is: ❑ medical care ❑ legal ❑ continuity care ❑ other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to the Director of Medical Records, Grinnell Regional Medical Center, 210 4th Ave., Grinnell, IA 50112. I understand that any release that was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Medical Records at the above address.

I understand that Grinnell Regional Medical Center and clinics of Grinnell Regional Medical Center may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

Specific Authorization for Release of Information Protected by State or Federal Law
I specifically authorize the release of data and information relating to the following (check the appropriate box or boxes):
❑ Substance Abuse ❑ Mental Health ❑ HIV-Related Information

_____ _____
*Signature of Patient or Legal Guardian Date
***In order for this specific information to be released, you must sign here *AND* above, and check the appropriate box(es).**

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months).

_____ _____
Signature of Patient or Legal Guardian Date

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, if not Patient Witness Signature

GRMC use only: Upon satisfying release, date and sign, and file the original in the medical record.
Information Sent: _____ _____
Name/Department Date

Consent to Release/Obtain Information

Grinnell Regional Medical Center - 210 4th Ave. Grinnell, Iowa 50112 (641) 236-7511 FAX - (641) 236-8400