Central Iowa OB/GYN Specialists, PLC

Bernard J. Munro, M.D., FACOG •

AUTHORIZATION FOR RELEASE OF INFORMATION
(please complete in full)

Patient name:

_____ _____ _____ _____
Last First Middle Date of Birth

_____ _____ _____ _____
Street Address City State SS Number

Authorize records release from:

_____ _____
Name Name

_____ _____
Address Address

_____ _____
City State Zip City State Zip

Release records to: _____

_____

Type or extent of information to be released: (Check all that apply)

_____ Medical history, examination, reports
_____ Operative Reports
_____ Treatment or test results
_____ X-ray reports
_____ Hospital Records, including reports
_____ Mental health records
____ Laboratory Reports
____ Prescriptions
____ Consultations
____ HIV test results
____ Copies of all other reports
____ Alcohol, drug abuse records

Purpose for release: ____ Continuing Medical Care ____ Transfer of Care to another physician
____ Moving
____ Personal copy
____ Other:_____

This authorization will remain in effect until _____

This authorization will be effective for medical records generated to the date of the above signature. I understand that I may revoke this authorization at any time by providing my written revocation.

_____ _____
Signature Date

If signed by a person other then patient, state the relationship
Patient is: _____ Minor _____ Incompetent _____ Deceased
Legal Authority: _____ Parent or Legal Guardian _____ Next of Kin of Deceased

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CENTRAL IOWA OB/GYN SPECIALISTS, PLC
BERNARD J. MUNRO, M.D., F.A.C.O.G.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

_____

Telephone: _____ Social Security #: _____

SECTION B: TO THE PATIENT
PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our policy practices as described in our Notice of Privacy Practices. If we change our primary practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

PERSONS AUTHORIZED TO OBTAIN MEDICAL INFORMATION

Contact name: _____
Relationship to patient: _____
Spouse, parent, child, sibling, friend

Home telephone number: _____/_____/_____
Work telephone number: _____/_____/_____

Contact name: _____
Relationship to patient: _____
Spouse, parent, child, sibling, friend

Home telephone number: _____/_____/_____
Work telephone number: _____/_____/_____

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.