CHEST, INFECTIOUS DISEASES AND CRITICAL CARE ASSOCIATES, P.C.

Account#: ____________________

CIC Dr.: ____________________

AUTHORIZATION TO OBTAIN INFORMATION

Please Print: Name: ____
Birthdate: ____

I HEREBY AUTHORIZE:

Name: ____
Address: ____
____
City/St/Zip: ____
Phone: ____
Fax: ____

TO DISCLOSE AND DELIVER TO:

Chest, Infectious Diseases and Critical Care Associates, PC
1601 NW 114th St, Suite 347
Des Moines, IA 50325-7046
Phone: (515) 224-1777 Fax: (515) 225-6750

The following Information (Date(s)/Exam(s) of Treatment to be released):

____
____
____

Purpose of Need for Disclosure:

☐ Personal Use ☐ Continued Patient Care ☐ Insurance Claim/Application
☐ Attorney/Legal ☐ Disability Determination ☐ Other (Please specify below)

____
____

SPECIFIC AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, AIDS/HIV-RELATED, OR SUBSTANCE ABUSE INFORMATION. I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS/HIV-related information.

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(515) 224-1777 · FAX (515) 225-6750 · www.cicdoc.com

I SPECIFICALLY AUTHORIZE the release of confidential information relating to the following [Place "YES" or "NO" in ALL applicable boxes]:

_____ **Substance Abuse (Drug or Alcohol) Information from:**

____

____

____

(Name of agencies, facilities, or individuals)

_____ **Mental Health Information from:**
NOTE: You have the right to inspect the disclosed mental health information at any time.

____

____

____

(Name of agencies, facilities, or individuals)

_____ **HIV/AIDS-related Information, Diagnosis, and test results from:**

____

____

____

(Name of agencies, facilities, or individuals)

Federal and/or State law specifically require that any disclosure of substance abuse, alcohol or drug, mental health, or HIV/AIDS-related information must be accompanied by the following written statement:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply. This consent will automatically expire one year from date signed. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from whom disclosure is sought in writing.

I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and/or Federal law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below.

I SPECIFICALLY AUTHORIZE AND CONSENT TO THE DISCLOSURE DESCRIBED ABOVE.

____ ____________________

Signature of Patient or Representative Date

____

Printed Name of Patient or Representative

____

Relationship to Patient

NOTE: PHOTOCOPY OF THIS SIGNED AUTHORIZATION SHALL BE AS EFFECTIVE AS THE ORIGINAL

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