



Coral West Health Center
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Authorization to Release Medical Records

Patient/Employee Name _____ DOB: _____ Last 4 of SSN _____

I, _____ hereby authorize:
(Patient/Employee/Guardian)

(From) _____
(Name of person or institution)

To release medical information via copies, viewing, or verbal to:

(To) _____
(Name of person or institution)

(Address)

- Check the information to be disclosed:
[] All records or Specify (include dates if necessary):
[] Report to Employer
[] Visit Notes
[] History and Physical
[] Laboratory Results
[] Audiogram Results
[] Other, specify:
[] EKG Results
[] Pulmonary Function Testing
[] Immunization Record
[] Respiratory Fit Testing
[] X-Ray and Imaging Reports

I understand that information to be released may contain information in the following categories unless I specifically deny the release. (Initial any category NOT to be released)

- 1. Substance Abuse (Drug/Alcohol abuse & testing)
2. Mental Health/Depression (includes psychological testing)
3. HIV- Related information (AIDS related testing)

Please provide reason for release:
[] Employment [] Insurance [] Legal
[] Moving out of area [] Transfer Care [] Other Medical Care [] 2nd Opinion

I may revoke this authorization at any time by sending written notice to the above address of the provider/clinic. I understand that any release made which has been made prior to my revocation of which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I also understand that recipients of this information may possibly release the information without proper authorization, and once information is disclosed it may longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the Health Information Department at the above named clinic. Mercy Services does not require completion of this form as a condition of evaluation or treatment. However, when the evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to the third party is not provided, it may result in the cancellation of those services. This authorization will expire one year from the date of signature, or as indicated _____ (specify number of days or months) unless cancelled by patient/guardian. I also understand that there could be a medical records fee plus postage if mailed.

Signature of Patient/Employee or Legal Guardian _____ Date _____

Address _____ City, State, Zip _____

Relationship to Patient _____ Witness _____