CONSENT TO RELEASE OF INFORMATION

Northwest Iowa Bone, Joint & Sport Surgeons (NWIBJSS)
Tel 712-262-7511; Fax 712-262-3658

Please neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name _____ **Birth Date** _____

By signing this form, I am allowing NWIBJSS to release/receive medical information concerning the above named patient to/from the person or facility listed below. I would like this information shared by: Viewing ___ Verbal ___ Copies ___ CD ___
(Please note, burning to a CD is only possible when transferring electronic information. Copies of paper documents will be provided on paper.)

Release records to	**Release records from**
Mailing Address/Street/P.O. Box; City, State, Zip Code	Mailing Address/Street/P.O. Box; City, State, Zip Code
Phone Number Fax Number	Phone Number Fax Number

Regarding injury or illness relating to my _____
Or specify dates (if any) _____
Check the information to be disclosed. Specify clinic or date if applicable:

___Minimum Necessary	__ Medication List	___ Allergy List
___Clinic Notes	__ History and Physical	___ Laboratory Results
___X-ray and imaging reports	__ Consultation/Operative Reports	___ Billing Information

Other, please specify _____

Please check the reason for release below; and provide date by which the info is needed: _____

___Insurance	___Second opinion	__ Rehab/disability	__ Personal file
___Moving out of area	___Legal	__ Other Medical Care	__ Transferring care

If transferring care, may we discuss this with you? __ Yes __ No
If yes, please indicate the best time and telephone number to reach you: _____

I understand that the information may be released electronically, and may include information in the following categories unless I specifically deny the release (**check** any category **not** to be released).
___Substance abuse ___ Mental Health ___ HIV-related information _____ Genetic tests/information*
*Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send a written notification to the Director of Health Information Management, Northwest Iowa Bone, Joint & Sports Surgeons, 1200 1st Ave. E, Suite C, Spencer, IA 51301. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) 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 Health Information Management at the above address.

NWIBJSS does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.

This agreement will expire one year from the date of signature, or as indicated (specify number of days or months) unless cancelled by the patient/guardian.

Signature of Patient or Legal Guardian	Date
Complete Mailing Address/Street/P.O. Box	City, State, Zip Code
Relationship, if not the patient	Witness Signature