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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