Family Medicine
of Mount Pleasant P.C.

501 S White St - Mt. Pleasant, IA – 52641
Phone #319.385.6700 – Fax #319.385.6703

CONSENT TO RELEASE OF INFORMATION (TO FMMP)

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

I, the undersigned, hereby authorize:

_____
Name of Physician / Person and/or Institution

_____
Address City State Zip Code

To release medical information concerning the above-named patient to the Medical Records Department of Family Medicine of Mt. Pleasant, PC at the above address.

This medical information will contain copies of progress notes, discharge summary letter, and/or clinical notes pertaining to the patients' evaluation and treatment. If additional information is necessary, please specify:

_____
The information is to be used for continuing medical care and/or second opinion.

This authorization is voluntary. 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 Medical Records Department at the above address.

Family Medicine of Mt. Pleasant, PC 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.

I understand that information may be released electronically and may include information in the following categories unless I specifically deny the release (*initial* any category *not* to be released).

Substance Abuse _____ Mental Health _____ HIV Related Information _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____.

_____ _____
Signature of the Patient/Guardian/Legal Representative Date Signed

Date Information Sent _____ By _____ *(For office personnel only)*