

**DERMATOLOGY, P.C.**  
6000 University Ave, Suite 450  
West Des Moines, IA 50266  
FAX (515) 241-2005

**CONSENT TO RELEASE PROTECTED HEALTH INFORMATION**

**\*\*\*THIS FORM MUST BE COMPLETED IN FULL OR IT WILL DELAY YOUR REQUEST\*\*\***

**Patient name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**By signing this authorization, I authorize**

**Name**

**City/State/Zip Code**

To release the following medical record information. Please be as specific as possible.  
(i.e.: dates seen, medical record, progress notes, pathology reports etc.....)

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WEST DES MOINES IA 50266**

I understand that I have the right to inspect the disclosed information at any time. This authorization will expire 60 calendar days from the signature date.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient as shown above and may no longer be protected by the federal HIPAA privacy Rule. I have the right to revoke this authorization except to the extent that the releaser has acted in reliance upon this authorization for record release prior to my written revocation. My written revocation of this authorization must be submitted to: Privacy officer of the record releaser

Please specify the reason for the release of these medical records:

\_\_\_\_\_ Transferring medical care      \_\_\_\_\_ Insurance  
\_\_\_\_\_ Dissatisfied with care      \_\_\_\_\_ Other \_\_\_\_\_

**SPECIFIC AUTHORIZATION FOR THE RELEASE OF RECORDS PROTECTED BY STATE/FEDERAL LAW**  
I specifically authorize the release of medical records relating to: (please check the appropriate box)

\_\_\_ **Yes** **Substance Abuse**      \_\_\_ **Yes** **Mental Health**      \_\_\_ **Yes** **HIV-related information**  
\_\_\_ **No**      \_\_\_ **No**      \_\_\_ **No**

\*\* This information has been disclosed to you from records protected by federal confidentiality rules for alcohol/drug abuse records (42 CFR part 2), state law for mental health records, (Iowa code Ch.228), and/or for HIV records (Iowa Code Ch.141). These rules/laws prohibit you from further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise allowed by law. A general authorization for release of medical or other information is insufficient for this purpose. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of this information. The federal rules pertaining to alcohol/drug abuse records restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Signature of patient or legal guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Initials (DPC employee)** \_\_\_\_\_