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Sameer A. Yaseen, M.D.
Candice R. Gruss, ARNP
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Taera A. Mulder, PA-C
Jessica J. Schaack, ARNP
Jana K. Van Haaften, ARNP

IOWA KIDNEY PHYSICIANS

Authorization to Release Health Information

Patient Information:

Name *(First, Middle, Last)*:	Birth Date *(Month Day, Year)*:

Release Health Information From:

Organization(s) Name: Iowa Kidney Physicians, PC

Mailing Address: 1215 Pleasant St, Ste 100. DSM, IA 50309/5500 Westown Pkwy, Ste 180, WDSM, IA 50266

Specific Health Care Professional's Name: _____

Release Health Information To:

Name (Organization or Person): _____

Mailing Address -- Street: _____

City: _____ State: _____ Zip Code: _____

Phone (optional): _____ Fax (optional): _____

Purpose of Release:

☐ Patient's Request ☐ Treatment / Continued Care ☐ Payment ☐ Insurance Application
☐ Disability Determination ☐ Legal ☐ Other:

Information to Be Released:

Dates of Service (optional): From _____ To _____

☐ All Health Information

OR to only release specific portions of health information, indicate the categories to be released:

☐ History / Physical ☐ Laboratory Report ☐ Radiology Report ☐ Medications ☐ Care Plan
☐ Pathology Report ☐ Clinic Notes ☐ Billing Information ☐ Immunizations ☐ Progress Note
☐ Other:

Specific Authorization for Release:

The following information requires a special consent. Even if you indicate all health information, you must specifically request the information to be released.

☐ Chemical Dependency Program ☐ Psychotherapy Notes ☐ HIV/AIDS Related Information ☐ Genetic Information (including test results)

Affirmation and Signature:

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. This authorization is voluntary. This authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to Iowa Kidney Physicians, P.C. Iowa Kidney Physicians, P.C. will not condition treatment on whether the authorization is signed. Copies may involve a copying charge in accordance with federal and state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____

Signature: _____ Date *(Month Day, Year):* _____

Printed Name of Person Signing *(If Not Patient)* _____ Relationship to Patient: _____