



Medical Associates Clinic, P.C. & Affiliated Entities
Release of Information: 1500 Associates Drive, Dubuque, IA 52002
Telephone 563-584-3207; Fax 563-584-3216
(Important: PRINT information)

DISCLOSE / EXCHANGE INFORMATION FORM

Patient's Full Name \_\_\_\_\_ Med History # \_\_\_\_\_

Previous Name/s (if any) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Last 4 digits of social security # \_\_\_\_\_

I authorize the Physicians and Providers of Medical Associates Clinic, P.C., 1500 Associates Drive, Dubuque, IA 52002, to verbally communicate with:

Name of Person granted permission \_\_\_\_\_

Relationship \_\_\_\_\_

Phone Number \_\_\_\_\_

I understand that the information to be disclosed may include information in the following categories and hereby specifically authorize such disclosure:

- YES NO Substance Abuse (drug or alcohol)
YES NO Mental Health (including psychotherapy notes, and/or ADHD, and/or autism)
YES NO AIDS/HIV-related information, diagnosis, and test results
YES NO Billing and Payment Information (Business Office)

IF NEITHER YES OR NO IS CHOSEN INDICATING DISCLOSURE PREFERENCE, NO INFORMATION IN THIS SECTION WILL BE DISCLOSED.

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to the Manager of Release of Information, Medical Associates Clinic, P.C., 1500 Associates Drive, Dubuque, IA 52002. 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 Manager of Release of Information at the above address. Medical Associates does not require completion of this form as a condition of evaluation or treatment. A photocopy of exact reproduction of this signed authorization shall have the same force and effect as the original.

This agreement will expire two (2) years from the date of signature, but in no case valid for more than two (2) years, or as indicated (specify number of days or months) \_\_\_\_\_, unless cancelled by the patient/guardian.

Signature of Patient or Legal Guardian \_\_\_\_\_ Printed name \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient (Parent, Guardian, Health Care POA, etc.) \_\_\_\_\_