TRINITY
IOWA HEALTH SYSTEM
Muscatine

AUTHORIZATION FOR RELEASE

Hospital ☐

1518 Mulberry Avenue
Muscatine, IA 52761
Tel: 563-264-9219
Fax: 563-264-9589

Physician Clinics

Main Family Practice ☐
1518 Mulberry Avenue
Muscatine, IA 52761
Tel: 563-262-4110
Fax: 563-264-0263

Internal Medicine ☐
Tel: 563-262-4111
Fax: 563-264-9175

OB/GYN ☐
Tel: 563-262-4113
Fax: 563-264-9167

Pediatrics ☐
Tel: 563-262-4115
Fax: 563-264-0166

Surgery/ENT ☐
Tel: 563-262-4112
Fax:563-264-8519

Cedar Street Clinics
1616 Cedar Street
Muscatine, IA 52761

Family Practice ☐
Tel: 563-262-4101
Fax: 563-264-9513

Occupational Medicine ☐
Tel: 563-262-4120
Fax: 563-264-3793

Orthopedics ☐
Tel: 563-264-9185
Fax: 563-264-9182

Public Health ☐
1609 Cedar Street
Muscatine, IA 52761
Tel: 563-263-0122
Fax: 563-263-0520

Wilton Clinic ☐
PO Box 370
Wilton, IA 52778
Tel: 563-732-2121
Fax: 563-732-4232

I, _____give my consent to (_____TRINITY MUSCATINE _____)
Facility name

Facility Address/phone number_____1518 MULBERRY AVENUE MUSCATINE, IA 52761_____

to release my records to_____
(Name & address of person/organization)

_____
Address/phone/fax number

Information from the medical record of:

Pt Name_____ Previous Name(s)_____

Date of Birth _____ SS# _____ Phone #_____

Address_____

Information Requested:

☐ X 1 year ☐ X3 Yrs.. ☐Lab ☐ Immunizations ☐ X-ray/films ☐Other

Dates from _____ **to** _____

For the purpose of ☐ Insurance(Fee will apply) ☐ Legal(Fee will apply) ☐ Continuing care
☐Transfering care ☐Personal (Fee will apply)
(Must be filled in)

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Trinity Muscatine.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.
3. This authorization is effective for one year after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to the Director of Health Information Management Services, Trinity Muscatine, 1518 Mulberry Avenue, Muscatine, Iowa, 52761. I have the right to review /inspect the disclosed material. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.
A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

****I understand that the information to be released 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**_____

➔**Signature of Pt/Legal Representative** _____**Date** _____

_____
(Relationship to patient and reason pt unable to sign)

Witness Signature _____ **Date**_____

Witness Pickup _____ **Date**_____