## **Authorization for Disclosure of Protected Health Information**

To be picked up

To be faxed



	•					
Patient Identification	Name:Date of Birth:					
identification				Phone:		
		Maiden/Previous Names/ Nickname: SSN#:				
Provider	Provid	er/Facility Name: <i>Oi</i>	range City Area Health System	Hospital	Medical Clinic	
(Who is releasing	Addres		<u>_</u>	Phone: 712-737-5248	Phone: 712-737-2000	
information?)	City/St E-mail		<u>IA</u> Zip Code: <u>51041</u> mation@ochealthsystem.org	Fax: 712-737-5280	Ext: 5153 Fax: 712-737-5280	
Disclose	E-mail	. ocheanminor	mation@ocheatinsystem.org			
Information To:	Name/Facility:			Phone:		
(Where is	Address:					
information to be sent?)		City/State:				
Information to be Disclosed	□ Hosp	pital Progress Notes	<ul> <li>□ EKG/Cardiology Reports</li> <li>□ Radiology Reports</li> </ul>	□ Pathology Report	_	
De Disciosed		_ Physician's Nurse's	☐ ER Records	☐ Psychiatric Evaluation☐ Outpatient Informatio		
		Other	☐ History & Physical	□ Consultation		
		_	□ Discharge Summary	□ PT Notes		
	□ Clini	ic Progress Notes Physician's	<ul> <li>□ Operative Report</li> <li>□ Immunization Record</li> </ul>	☐ All Records	<b>\</b>	
		_ Filysician's Nurse's	☐ Treatment for Drug or	☐ Other (Please Specify)	)	
		_ Other	Alcohol Dependency			
			□ Lab Data			
			□ Radiology Images (specify dates)			
Service Dates	Time p	period from	to			
Service Dates	Time p Concer	period from rning:				
	Conce	rning:	(specific diagnosis or treatment,			
Service Dates  Purpose of Disclosure	□ Cont	rning:tinuing Medical Care rance Claim	(specific diagnosis or treatment, a  □ Consult/Second Opinion  □ Legal	auto accident, etc.)  □ Out of town move □ Personal		
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