630 E. 4th St. #A Davenport IA 52803

Phone 563.324.9177 Fax 563.323.0217

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patients full name: _____

Date of Birth: _____Phone Number: (_____) _____

I authorize the disclosure of information from my records for the following purpose/s: ☐ Personal copy ☐ medical treatment ☐ insurance/disability ☐ legal matter ☐ research (may require special consent) ☐ discussing/coordinating of personal care with my personal representative ☐ Other_____

- I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law.
- I understand that I have the right to revoke this authorization, in writing, at any time to Midwest Cardiovascular Research Foundation, 630 E. 4th St. #A, Davenport, IA 52803. I understand that such a revocation is not effective to the extent that Midwest Cardiovascular Research Foundation, has relied on the use or disclosure of the protected health information.
- I understand that Midwest Cardiovascular Research Foundation, will not condition treatment or eligibility for care on my providing this authorization except if such care is provided solely for the purpose of created protected health information for disclosure to a third party.
- I understand that information disclosed by this authorization may be subject to disclosure by the recipient and may no longer be protected by the health insurance Portability and Accountability Act Privacy Rule.
- Payment: There may be fees associated with some medical record requests. If your request requires a fee for processing, you will be contacted for pre-payment of the fee, prior to processing your request.

Signature of patient or patient's legal representative:	Date:
Printed Name:	Relationship to patient (if other than patient):

OFFICE USE ONLY

Information to be DISCLOSED BY: Information to be PROVIDED TO:

Name:		**Name:** Midwest Cardiovascular Research Foundation	
Address:		**Address:** 630 E. 4th St.	
City/State/Zip Code:		**City/State/Zip Code:** Davenport/Iowa/52801	
Phone:	**Fax:**	**Phone:** 563-324-9177	**Fax:** 563-323-0217
		Attention: Leanna Kellenberger	

The Information to be disclosed from my health record: (Check appropriate boxes)

☐ Entire record

☐ Only information related to (echo, office visit) _____

☐ Only records from_____

☐ Other (specify) _____