Koithan, P.C. & Align Health Services
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____ **Birthdate** _____/_____/_____

Address_____

I authorize the following parties:

1) **Dr. Thomas Koithan**

2)_____
Name **Address** **Telephone**

…..to disclose the information initialed below from my medical records to one another.

Please initial all that apply:

____ Discharge Summary
____ Social History
____ Laboratory, X-Ray, EKG
____ Treatment Status
____ History and Physical
____ Mental Health/Substance Abuse
____ Consultation
____ Other (please specify) _____

The information is being requested for the following purpose(s): _____

_____

I understand that I may revoke this authorization by providing a written revocation to the parties named above at any time. I also understand that any information which has been released prior to the revocation may be used for the purposes listed above. This authorization is effective for: **(Please initial)** _____ **indefinitely until revoked OR** _____ **twelve months** from the date on which it is signed. I understand that I may have a right to inspect disclosed information at any time and that such inspection will occur in a meeting with a member of the professional staff.

I acknowledge that the information to be released may include material that is protected by state and/or federal law applicable to either mental health or substance abuse or both. My signature authorizes release of all such information.

_____ _____
Signature of Patient or Patient's Authorized Representative **Date**

_____
If authorized Representative, Relationship to Patient

PROHIBITION ON REDISCLOSURE
This form does not authorize redisclosure of Medical Information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for substance abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa code ch. 22) prohibits further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other Information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of substance abuse or mental health Information.