WEBSTER CITY MEDICAL CLINIC

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I. PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: ____

Maiden or Previous Name(s): ____

Date of Birth: ____________________ Social Security #: ____________________

The undersigned hereby authorizes: WEBSTER CITY MEDICAL CLINIC

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to release copies of medical records dated: ____

relating to the above named patient to: ____

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Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information will be released unless indicated otherwise in Section II of this form.

A photocopy, or exact reproduction of this signed Authorization shall have the same force and effect as the original.

I hereby authorize the release of information as indicated above.

____ ____________________
Signature of Patient or Legal Guardian Date

____ ____________________
Relationship, if NOT the patient Witness

II. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I specifically authorize the release of confidential information relating to:
(Place "YES" or "NO" in ALL applicable boxes.)

☐ Substance Abuse (Drug or Alcohol) information

☐ Mental Health Information

☐ AIDS-related information, Diagnosis, and the test results

Furthermore, I SPECIFICALLY AUTHORIZE disclosure of this confidential information to all persons or facilities referred to in the above section. In order for the above information to be released, you must sign here AND SECTION I.

____ ____________________
Signature of Patient or Legal Guardian Date

____ ____________________
Relationship, if NOT the patient Witness