VIRTUE MEDICINE P.C.

Clinics for Mind-Body Health

Studio for Ethics & Contemplative Arts

Request for Release of Medical Information

Patient: _____ Date of Birth: _____

Address: _____

Individual/Entity: _____

Address: _____

_____

Phone: _____ FAX: _____

The individual/entity is authorized to release information about the above-named patient.

❑ For further medical evaluation, treatment, or care ❑ Other: _____

The information to be disclosed is marked by an X, concerning the time between _____ and _____.

❑ Hospital admission and discharge summaries ❑ Medical history and evaluation(s)

❑ Mental health evaluations ❑ Progress notes and treatment plans

❑ Other: _____

❑ Please forward copies of the requested records to: _____, **Virtue Medicine P.C., 221 East College St. Ste 212, Iowa City, IA 52240. Phone: 319-338-5190. Fax: 319-354-3718**

❑ Please release information in one of the following format(s):

Hard Copy Fax CD/DVD Phone Other_____

HIV-related and drug/alcohol information in the records are authorized for release **unless** indicated here:

❑ Do not release HIV-related information ❑ Do not release drug and alcohol information

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. I release the source of the records from any and all liability incurred through release of my records. This request is entirely voluntary on my part. I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken.

This consent will expire automatically **in 2 years**, or ❑ _____ from the date on which it is signed, unless revoked in writing. I agree that a photocopy of this form is valid, if signed by patient or legal guardian.

_____ _____ _____

Patient Signature Printed Name Date