Jacqueline M. Stoken, D.O., P.C.
1454 – 30th Street, Suite 109 West Des Moines, IA 50266
Phone: 515-327-0046 Fax: 515-327-9389

Authorization for Release of Confidential Health Information

I, _____ _____, authorize the following:
(Printed Name of Patient or Authorized Agent) *(Birthdate)*

_____ _____ _____
(Health Care Facility, Physician, Agency, etc.) *(Health Care Facility, Physician, Agency, etc.)* *(Health Care Facility, Physician, Agency, etc.)*

_____ _____ _____
(Street Address, City, State and Zip Code) *(Street Address, City, State and Zip Code)* *(Street Address, City, State and Zip Code)*

to release to Jacqueline Stoken, D.O., P.C.

Please initial and check all that apply:

_____ ☐ My entire medical record, ***excluding*** mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records

_____ ☐ Laboratory Reports

_____ ☐ X-ray Reports

_____ ☐ MRI/CAT Scan Reports

_____ ☐ Other: _____

_____ ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records

_____ ☐ Mental Health Treatment Records

_____ ☐ Alcoholism Treatment Records

_____ ☐ Drug Abuse Treatment Records

The above information for the following period of time shall be released:

☐ All dates of service

☐ From _____ to _____
(Date) *(Date)*

The purpose of the authorization is for:

☐ Continued care

☐ Other Reason _____.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. In the absence of such written revocation, **this Authorization for Release of Confidential Health Information will terminate one year from the date signed below** or on _____ *(Date).*

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____.