ICS Consent to Release Information

Please PRINT (except signature) and provide complete information in each section.

ICS

Iowa Cancer Specialists

Susannah Friemel, M.D.
Linda Jager, M.D.
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Member

SWOG

NRG ONCOLOGY

CTSU

1750 E. 53rd Street
Davenport, Iowa 52807
(563) 345-(HEAL) 4325
Fax (563) 345-4326

_____ / _____

Patient's Legal Name **Birth Date**

By signing this form, I am allowing the following entity to release medical information via copies, fax, viewing, electronic or verbal means concerning the above named patient to:

Iowa Cancer Specialists, P.C. **Phone: 563-345-HEAL (4325)**
1750 E 53rd Street, Davenport, Iowa 52807 **Fax: 563-345-4326**

Information is Requested from (Dr's office): _____

Information disclosed should include information from any boxes marked below regarding the following time period and / or medical issue:

_____

Time Period: From _____ to _____

Date Request Made: _____ Info needed by: _____

	History & Physical		Medication / Allergy List		Exam / Office Notes
	Consultation Reports		Radiology/Procedure Reports		Appointment Info
	Discharge Summary		Laboratory Results		Immunization History
	Treatment History / Plan		Pathology Reports		Genetic Testing Reports

Information to Patient:
This authorization is voluntary. If I choose to cancel this consent at a later date, I must send a written notification to the Director of Health Information Management, Iowa Cancer Specialists, P.C. At the address listed above, If this consent is canceled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management.

ICS does not require completion of the form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a 3rd party, if authorization to release the information to the 3rd party is not provided, it may result in the cancellation of services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release. (Initial any category NOT to be released).
_____Substance Abuse ____Mental Health _____HIV-related info _____Genetic Testing Info

This agreement will expire one year from the date of signature, unless canceled by the patient/ guardian, or as indicated (specify number of days or months): _____.

X _____ _____ **Date:** _____
Signature of Patient or Legal Guarding & Relationship, if NOT the patient

Mailing Address:

_____
Street / PO City, State, Zip Code

Witness Signature: _____