MRE Family Care Clinic

MRE Family Care Clinic
404 E. Bloomington Street, Iowa City, IA 52245
Phone: 319.351.1483 Fax: 319.351.1027
Web: mrefamilycare.com

Authorization to Release Medical Records

Patient name:_____ Birth date:_____/_____/_____

I, _____, authorize:
(patient/guardian name)

_____
(name of person/institution)

To release medical information and history via copies, viewing, or verbal to:

MRE Family Care Clinic, LLC
404 E. Bloomington Street
Iowa City, IA 52245
Phone: 319.351.1483 **Fax:** 319.351.1027

Please indicate which information is to be disclosed: ❒ All records (or indicate below)

❒ Allergy list
❒ Consult Reports
❒ History and physical
❒ Laboratory Results
❒ Problem List
❒ Billing Information
❒ Discharge Summary
❒ Immunization Record
❒ Medication List
❒ X-Ray and Imaging Reports
❒ Other: _____

Reason for information release:

❒ 2nd opinion
❒ Insurance
❒ Legal
❒ Moving out of area
❒ Transfer of Care
❒ Other medical care

I understand that information to be released may contain information to be released in the following categories unless I specifically deny the release. ***(Initial any category NOT to be released)***

___ Substance abuse (drug/alcohol abuse & testing)

___ Mental health/depression (includes psychological testing)

___ HIV-related information (AIDS related testing)

_____ _____
(signature of patient or guardian) (date)

_____
(address, city, state, zip code)

_____ _____
(relationship to patient) (phone)