



Name of Staff Member Initiating Release _____
 Same Day Release _____ ScanStat Release _____

Consent to Release Information

River Drive Clinic 500 West River Drive Davenport, Iowa 52801 563-336-3000 – Phone 563-336-3125 – Fax	Dental Clinic 125 Scott Street Davenport, Iowa 52801 563-336-3221 – Phone 563-336-3229 – Fax	Moline Clinic 1106 4 th Avenue Moline, IL 61265, 563-327-2000 – Phone 563-327-2045 – Fax	Rock Island Clinic 2750 11 th Street Rock Island, IL 61201 563-327-2100 – Phone 563-327-2102 – Fax	East Moline 708 15 th Avenue East Moline, IL 61244 (563)336-3000-Phone 563-336-3212-Fax
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Patient Name _____ Chart # _____
 Date of Birth _____

Information to be released from:

Name/Agency: River Drive Clinic
 Address: 500 West River Drive
 City/State/Zip Davenport, IA. 52801
 Phone: 563-336-3000 Fax: 563-336-3125

Send requested medical information to:

Name/Agency: Black Hawk Area Special Ed Dist.
 Address: 4670 11th Street
 City/State/Zip East Moline, IL. 61244
 Phone: 309-796-2500 Fax: 309-796-2911

CHECK INFORMATION NEEDED:

- Immunizations Progress Reports Lab Reports Radiology Reports/X-ray Consult/Referrals
 ER/Hospital Other Diagnosis, Medications and Restrictions.

Please check any items that you **DO NOT** want to be released. If left unchecked information will be released.

- STD's Mental Health Substance abuse (drug/alcohol) HIV/Aids Genetic testing Infectious disease

This information is required for:

- Transfer of care Personal Copy Consultation/Referral Dissatisfaction with the clinic, please specify: _____

*** Eligibility for DHS-DRS Services.

How would you prefer to receive your records: Paper Records CD

I give permission to release only the information I've selected on this form to the individual(s) or agency(s) I've named and only for the purposes that I've checked. I understand that this release is valid for 60 days and I may refuse to sign this authorization or revoke this authorization at any time. If I revoke or refuse to sign, it will not affect my ability to obtain treatment or my eligibility for benefits. The revocation will take effect on the day a signed copy is received by Community Health Care. I have the right to access my treatment records. Copies of my records may be obtained with reasonable notice. I understand if the person or entity that receives the release of information is not a health care organization covered by the federal privacy regulations or a business associate of that organization that the information may be redisclosed and no longer protected.

Patient Signature _____ Date _____

Signature of Representative _____ Date: _____

Authority to represent individual: Parent Guardian Power of Attorney Authorized Representative

For Same Day Release: I have verified the identity of the patient and obtained a photo ID of the person to whom the authorized release is to be made.

Staff Signature _____ Date _____