AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, __________________________________ ______________________
(Print Full Name) (Date of Birth)
hereby authorize the release of my health information

to:

Derek A. Campbell, Ph.D.
6200 Aurora Ave, Suite 202W
Urbandale, IA 50322
Ph: (515) 252-2522
Fax: (515) 252-2523

from:

Name: ____________________________
Address: ____________________________
City, State, Zip: ____________________________
PHONE: ____________________________
FAX: ____________________________

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure: Continuity of Care

Information requested:
___ History & Physical
___ Most Recent Office Notes
___ All Records For Specified Date Range______________to__________________
___ Neuroimaging Reports
___ Other____
____

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 90 days after the date signed. The requestor should not re-disclose my medical record to another party without further written consent.

Date: ____________ Signature: _______________________________
(Patient or Legal Representative)