FLOYD COUNTY
MEDICAL CENTER
Delivering Advanced, Personalized Care

Joseph P. Molnar, D.O. | Paul H. Royer, M.D. | David V. Schrodt, M.D | David G. Schweizer, M.D. | Janet Tull, M.D.
Jodi L. Heyer, PA-C | Joanne K. Starr, ARNP | Judi L. Halbach, ARNP, CNM | Kayla A. Kellogg, DNP
Phone: (641) 228-5151 | Fax: (641) 228-2902 | fcmcclinic@fcmhosp.com

Authorization of Use and Disclosure of Protected Health Information (PHI)

Patient Information:

Name _____ Date of Birth _____ Social Security Number _____

Maiden and/or other Last Name(s) _____ Phone Number _____

Street Address _____ City _____ State _____ Zip Code _____

Records From □ **Records To** □	**Records From** □ **Records To** □
Floyd County Medical Center- Clinic Name	_____ Name
1501 South Main Street, Suite 6 Street Address/P.O. Box	_____ Street Address/P.O. Box
Charles City, IA 50616-3444 City, State, Zip Code	_____ City, State, Zip Code
(641) 228-5151 (641) 228-2902 Phone Number Fax Number	_____ Phone Number Fax Number

IMPORTANT NOTE: When sending records to FCMC- Clinic, if over 50 pages please send via mail or CD. Unable to accept faxes over 50 pages.

I Am Requesting This Information To Be Released For The Following Purpose:
__ Continuation of Care __ Self (*Fees may be charged)
__ Changing Primary Care Physician __ Other: _____

Check the specific Protected Health Information to use or disclose, please include date(s):
__ Entire Record __ Lab Results __ Immunization Records
__ Office Notes __ X-Ray Results __ Other- Specify_____

_____ I do authorize transmission of my medical information by FAX machine.
_____ I authorize transmission of my medical record by email. I understand that even when encrypted, emailed information could be read by a third party and FCMC cannot guarantee secure delivery.

For date(s) of treatment or condition: _____

If I do not check the box below, information in my health record relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse is authorized to be released by my signature below. □ DO NOT RELEASE THE ABOVE LISTED INFORMATION.

I understand this authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to the Floyd County Medical Center- Clinic, C/O Medical Records Dept., 1501 S Main Street, Suite 6, Charles City, IA 50616-3444. I understand that any release that was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure, and 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 Medical Records Dept. at the above phone number.
This agreement will expire **one year from the date of signature**, unless previously revoked or otherwise indicated (specify date: _____).

Signature_____ Date_____
Patient/Legal Representative

_____ Date_____
Relationship to Patient

_____ Date_____
Witness

FCMC-Clinic Use Only:
Date Received: _____ Date sent: _____ Processor: _____ Information: □ Mailed □ Faxed □ Picked up

Records Picked Up By: _____ Date: _____