FIRST CARE MEDICAL CENTER

DR. VIKRANT SALARIA, M.D., SHELLY NANDA, M.D., DR. STEPHEN SMITH, M.D., DR. MARGARITA RODRIGUEZ ESCOBAR, M.D.

REQUEST FOR RELEASE OF INFORMATION

The undersigned acknowledges their lawful authority to request the release of patient's records. The undersigned and listed patient has hereby requested the transfer of said records and we hereby, request that you release the following patient's records:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME (Last, First): ______________________________

FORMER NAME (Last, First): ______________________________

BIRTH DATE (dd mm yyyy) ______________________________

SSN: ______________________________

CURRENT ADDRESS: ______________________________

City, State, Zip ______________________________

PHONE: ______________________________

THIS REQUEST AND AUTHORIZATION REFERS TO:

☐ Health care information relating to the following treatment, condition, or dates of treatment:

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☐ All health care information

☐ Other: ______________________________

REASON FOR RELEASE______________________________

	MEDICAL RECORDS FROM:	MEDICAL RECORDS TO:
Dr or clinic name:	______________________	**First Care Medical Center**
Address:	______________________	**800 Mercy Dr. Ste 120**
City, State, Zip:	______________________	**Council Bluffs, IA 51503**
Phone #:	______________________	**(712)388-2770**
Fax #:	______________________	**(712)388-2771**

I understand that these records may contain information regarding the diagnosis or treatment of HIV (AIDS Virus), other sexually transmitted diseases, drug and/or alcohol abuse and/or treatment, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. I understand that this request for release is effective for 90 days. ***SIGNATURE OF THE PATIENT IS REQUIRED OF ALL PATIENTS 18 YEARS OF AGE OR OLDERS. PARENT OR LEGAL GUARDIAN MAY PROVIDE AUTHORIZING SIGNATURE IF THE PATIENT IS A MINOR.***

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PATIENT'S SIGNATURE PATIENT'S LEGAL GUARDIAN/REP.

______________________________ ______________________________

SIGNATURE OF WITNESS RELATIONSHIP OF PATIENT