PMG Research of McFarland Clinic
Medical Records Release Form
1015 Duff Avenue
Ames, IA 50010
Office: (515) 956-4159 Fax: (515) 956-4198

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____
Last First Middle/Maiden
Address: _____
Street Address City State Zip Code
Date of Birth: _____

Authorization: I voluntarily authorize and direct PMG Research of McFarland Clinic ("PMG") to use and disclose my health information specified below to the following Primary Care Physician or Recipient:

Primary Care Physician: _____ Phone: _____
Address: _____ Fax: _____
_____

Recipient's Name: _____ Phone: _____
Address: _____ Fax: _____
_____

PMG may release information to these Family Members I authorize: _____
_____

Purpose or Need for Disclosure. (check applicable categories).

- ☐ Further Health Care
- ☐ Insurance/Claims
- ☐ Application for Insurance
- ☐ Legal
- ☐ Personal
- ☐ Disability
- ☐ Academics
- ☐ Other:_____

Information To Be Disclosed: This Authorization permits PMG to disclose the following health information**. PLEASE INITIAL WHICH OF THE FOLLOWING CATEGORIES/TYPES OF PROTECTED HEALTH INFORMATION THAT YOU AUTHORIZE US TO DISCLOSE:**

____ All of the medical records that PMG has in its possession.
____ All of my medical records except for the following: _____
____ Only the following records or types of health information: _____

Re-disclosure: I understand that once PMG discloses my health information to the Physician or Recipient identified above, PMG cannot guarantee that the Physician or Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

_____ I understand that if my record contains **information concerning mental health and/or drug and alcohol treatment,** I hereby authorize the release of such information.

_____ I understand that if my record contains **confidential HIV related information,** I hereby authorize the release of such information. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Term of this Authorization: This Authorization will remain in effect:
(To be completed by patient.)

- ☐ From the date of this Authorization until one year after the study completes.
- ☐ From the date of this Authorization until the _____day of _____, 20____.
- ☐ Until PMG fulfills this request.
- ☐ Until the following event occurs: _____.

Refusal to sign/Right to Revocation: I understand that I may refuse to sign or that I may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to PMG at the address listed below. The revocation will be effective immediately upon the receipt by PMG of my revocation, except that the revocation will not have any effect on any action taken by PMG in reliance on this Authorization before it received my written notice of revocation.

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Questions: I may contact the Privacy Officer for answers to my questions about the privacy of my health information. The Privacy Officer can be reached by phone at (336) 608-3500 and ask for the Privacy Officer or email at privacyofficer@pmg-research.com.

Signature:

_____ _____
Research Participant's Signature Date

If the Research Participant's is unable to sign this Authorization, I am the Legally Authorized Representative and have the authority to sign this Authorization.

_____ _____ _____
Name Legal Relationship Date

Witness Signature (applicable only if the Research Participant or the Legally Authorized Representative signs with the letter "X")

_____
Witness' Signature Print Name Date