Piper Family Medicine, PC

1630 42nd St NE, Suite F
Cedar Rapids, IA 52402
p: (319) 261-1379
f: (319) 261-1382

Medical Records Release Request

Patient Legal Name:_____
Date of Birth:_____Telephone:_____
Address:_____
City:_____State:_____Zip:_____

I hereby authorize the release of my Protected Health Information as follows:

☐From: ☐To:
Name of Facility:_____
Physician:_____
Address:_____
Phone:_____Fax:_____

☐From: ☐To:
Piper Family Medicine, PC
Scott Piper, MD
1630 42nd St NE, Suite F
Cedar Rapids, IA 52402
Phone: (319) 261-1379
Fax: (319) 261-1382

Purpose of Release:_____

Type of Information to be Released:
☐ Entire Medical Record (including sensitive information as described below)
☐ Entire Medical Record EXCLUDING ☐Mental Health ☐HIV testing/results
☐Substance Abuse
☐ A Summary of my Medical Record (which may include sensitive information as described below)
☐ Specific Information Only:_____

Sensitive Information:
I am aware that my medical record may contain sensitive information include drug or alcohol abuse diagnosis and treatment; sexually transmitted diseases and HIV/AIDS testing or treatment; mental health diagnosis and treatment; sexual identity, preferences, and practices; genetic testing and family history.

Release Expiration:
☐ At the fulfillment of this release ☐On specified date:_____

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Name of Legal Guardian Relationship to Patient