



905 29th Ave Marion, Iowa 52302 Phone: 319-826-6374 Fax: 319-826-6377

**Medical Records Release**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

**I hereby authorize the release of the following health information:**

Complete Record  Immunization Record  Physicals  Lab/X-Ray Reports  
 Sick Visits  Other \_\_\_\_\_  Date Range: \_\_\_\_\_ to \_\_\_\_\_

**The following information will only be released with your initials on the line next to it:**

Mental Health (including ADHD/ADD)  Alcohol Drug Information  
 Sexually Transmitted Diseases/Testing  HIV Testing & Results  
 Pregnancy  Abortion  Sexual Assault

**Reason for Request:**

Healthcare/Specialist  Legal  Personal  Moving  Transferring Care  
 Change of Insurance  Adult Care  Dissatisfied with Care (explain below)  Other (Explain Below)

**Comments:** \_\_\_\_\_

**Records to be sent to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Records to be sent from:**

Infinity Medical Clinic  
905 29th Avenue, Ste 120  
Marion, IA 52302  
Phone: 319-826-6374 Fax: 319-826-6377

\_\_\_\_\_  
Person Completing Form (Print Name)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Person Completing Form (Signature)

\_\_\_\_\_  
Date

**In accordance with current standards and laws, your signature on this form authorizes us to release your medical records to the requested individual or entity. Please consider that our records may contain records from another health care provider or hospital. If you do not want this portion of your record forwarded, you must inform us at the time this form is signed. Please note that we are not otherwise responsible for this info.**