Infinity Medical
LARAE STEMMERMAN, D.O.

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:

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

Records to be sent from:

_____
_____
_____
_____

_____ _____
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.