STATERA
Integrated Health & Wellness Solutions

3375 Lake Ridge Dr. Dubuque, IA 52003
Phone: (563)-207-8932 Fax: (563) 207-8935

Authorization to Release or Obtain Medical Information

Make sure all blanks are filled in, failure to do so may prevent or delay release of information

Patient Name: _____ DOB:_____ SSN_____

I authorize Statera Integrated Health and Wellness Solutions to _____Release to _____ Obtain from:

Facility/Provider Name:_____ Fax Number:_____
Address_____

Information to include:

_____Complete Record _____Lab Data _____EKG _____Treatment Progress
_____History & Physical _____Imms record _____X-ray _____Psychological Eval
_____Discharge Summary _____ Recommendations _____Office Notes (date _____)

Please be aware that Statera, LLC may impose a fee to cover costs involved in processing this release of information.

Reason for request: ____Transfer Medical Care ____Insurance Coverage ____Shared Care ____Consult

Statera will not condition treatment on your signing this authorization, unless: (1) you are receiving research-related treatment; or (2) the only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., PE physical).

Specific Authorization for Release of Information Protected by State or Federal Law

Unless otherwise indicated, my signature authorizes the release of the medical records requested above without exception; including any information concerning HIV/AIDS or AIDS Testing, Psychological or Psychiatric Treatment, Alcohol or Drug Abuse, Genetic Testing. Exceptions:_____

The authorization is effective for one year from the date on which is was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Statera, LLC. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under appropriate conditions established by Statera, LLC. The statement made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Statera, LLC Notice of Privacy Practices.

_____ _____ _____
Signature (Patient) Signature of Parent or Guardian Date

PROHIBITION OF REDISCLOSURE : Where information has been disclosed from records protected by federal law of alcohol/drug abuse records or by state law for mental health records, federal requirements (42.C.F.R. Part 2) and state requirements (Iowa Code ch. 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is no sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. I understand all other information used and/or disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.