The Center for Medicine and Healing Arts

KARYN SHANKS MD
Heart. Hope. Healing

Karyn M. Shanks, MD, FACP
610 Eastbury Drive, Suite 5
Iowa City, IA 52245
(319) 358-9510

Authorization for Release of Medical Information

Please mail records. DO NOT FAX!!

Please send this form *directly* to the provider(s) you wish us to receive information from. Thank you!

Name: _____ Birth Date: _____

Address: _____

Social Security Number: _____

I, the undersigned, do authorize and request that Kylemore Center for Medicine and Healing, LLC RELEASE TO or SECURE FROM _____
(circle one)
_____information from my medical records for care and treatment that I received from _____to _____(give dates) for:

O General Medical Care O Substance Abuse O Entire Chart

O Mental Health Treatment O HIV/AIDS treatment

Purpose of record transfer: _____.

This authorization will be valid for a one year period of time, unless a shorter period is specified. Specific number of days or months: _____.

I may revoke this authorization at any time by doing so in writing.

I acknowledge that information to be released may include material that is protected by state and/or federal law applicable to mental health, alcohol/drug abuse, HIV/AIDS or all of these. My signature authorizes release of all such information as specified above.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____ _____
Relationship of Authorized Representative Witness Signature/ Date