Complete Care of Iowa, LLC
113 E Marion St Sigourney IA 52591
641-541-4040

Authorization For The Release Of Healthcare Records

I hereby request and authorize: Complete Care of Iowa, LLC. 113 E. Marion Street, Sigourney, IA 52591 to disclose, receive and/or exchange my health information, as indicated below, with/from the practitioner or individual named below.

This authorization will be effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Please submit records via fax or email
Fax: 870-339-6698
Email: meganm@completecareofiowa.com

Select Preference*

- [ ] To Disclose info
- [ ] To Receive Info
- [ ] To Exchange Information with

Provider/Individual Name*

Provider/Individual Number*

Provider/Individual Address*

Information to be disclosed includes copies of:*

- [ ] Entire Record
- [ ] Progress Notes
- [ ] Appointment Dates / Times / Costs
- [ ] Lab Results for one year

Other Specifications*

Patient Name*

Patient Date of Birth*

Name of Legal Representative/Relationship: *

Close