GRAPE TREE
MEDICAL STAFFING

RELEASE OF INFORMATION AUTHORIZATION

Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

I authorize GrapeTree Medical Staffing to release my personal information identified below to the following:

Name: _____ Phone: _____

Address: _____ Fax: _____

City, State, Zip: _____

Specific Information Authorized: _____

Delivery Method: (check one)

☐ Email: _____

☐ Fax Number: _____

☐ Mailing Address: _____

☐ Pick-up Date: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect me in any way.
- I may cancel this authorization at any time by submitting a *written* request to GrapeTree Medical Staffing, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge for the requested records.
- I must submit this completed form, along with $30 to GrapeTree before my documents will be released.

Signature: _____ Date: _____

GrapeTree Representative: _____ Date: _____

2501 Boji Bend Drive, Suite 100, Milford, IA 51351

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