

Authorization for Release of Medical Information

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the entity authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. This authorization is effective for one year from the date on which it 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 Central Iowa Pediatric Allergy and Pulmonology. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions by Central Iowa Pediatric Allergy and Pulmonology.

Patient Identification	Name (Last, First, Middle Initial) _____ Date of Birth: _____ Any previous names under which records may be kept: _____ Telephone number where we can reach you if we have questions: (____) _____
Healthcare Provider (Who is releasing the information?)	Name: <u>IPAA Iowa Pediatric Asthma & Allergy LLC</u> Street Address: _____ City, State, Zip: <u>Scott Sheets, DO</u> <u>Country Club Office Plaza • Bristol Building</u> <u>7029 Vista Drive</u> Telephone Number: (515) <u>905-0220</u> West Des Moines, IA 50266 Fax Number: <u>515 223-3022</u>
Recipient (Who is to receive the information?)	Name: <u>University of Iowa Hospitals & Clinics</u> Street Address: <u>200 Hawkins Drive</u> City, State, Zip: <u>Iowa City, IA 50242</u> Telephone Number: (____) _____ Fax Number: (____) _____
Purpose of the Release (Check all that apply)	<input checked="" type="checkbox"/> At request of the patient (or legal representative) <input type="checkbox"/> Discussion/coordination of care with family members involved with patient's care <input checked="" type="checkbox"/> Transferring medical care to another healthcare provider <u>Saul's</u> <input type="checkbox"/> For claims processing (eg., third-party liability claims) <input type="checkbox"/> Other (please specify): _____
Information (What information should be released?) (Check all that apply)	<input type="checkbox"/> Records dating from: _____ to _____ <input checked="" type="checkbox"/> Only records created by this office <input checked="" type="checkbox"/> Other (please list specific records): <u>All on file for IPAA.</u>

I understand that the information to be released may include information in the following categories unless I specifically deny the release: (Initial any category NOT to be released)

Substance Abuse Mental Health HIV Related Info

All are released. please initial

I understand my healthcare and payment for my healthcare will not be affected by this authorization.

Signature of patient or legal representative: _____ Date: _____

Relationship to patient, if signed by legal representative: _____

PROHIBITION OF REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse treatment records or by state law for mental health records, federal requirements (42 CFR part 2) and state requirements 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 not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized of alcohol/drug abuse treatment of mental health information.