Iowa Pediatric Asthma & Allergy LLC
7029 Vista Drive
West Des Moines, IA 50266
Phone: 515-868-0220 Fax: 515-223-3022

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: IPAA Iowa Pediatric Asthma & Allergy LLC Street Address: Scott Sheets, DO City, State, Zip: Country Club Office Plaza • Bristol Building Telephone Number: (515) 868-0220 7029 Vista Drive West Des Moines, IA 50266 Fax Number: (515) 223-3022
Recipient (Who is to receive the information?)	Name:_____ Street Address:_____ City, State, Zip:_____ Telephone Number:(____)_____ Fax Number: (____)_____
Purpose of the Release (Check all that apply)	☒ At request of the patient (or legal representative) ☐ Discussion/coordination of care with family members involved with patient's care ☒ Transferring medical care to another healthcare provider ☐ For claims processing (eg., third-party liability claims) ☐ Other (please specify): _____
Information (What information should be released?) Check all that apply	☐ Records dating from:_____ to _____ ☐ Only records created by this office ☒ Other (please list specific records): All files from IPAA. All are to be released (Please initial)

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 ____

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.