



Authorization to Release or Obtain Medical Information

Please complete all fields to prevent delays in processing.

Patient Information

Name _____ Date of Birth _____
Parent/Legal Guardian Names _____

Medical Provider

(From where are your records originating)

Name _____
Address _____

Fax Number _____

Requestor

(Where do you want your information sent)

Name _____
Address _____

Fax Number _____

Processing Information & Fee

Records include: Complete History & Physical
Diagnostic Testing & Results
Immunization Records
Correspondence with Other Physicians
Other (please specify) _____

When we transfer your records out to another clinic, we incur staff and material costs at the rate of \$15/child or \$30/family. Large records may incur additional costs. Please submit payment with the records transfer request and please allow 7-10 business days for processing. We will need payment before processing the records.

Purpose for Release

Specific authorization for release of information protected by state or federal law:
Please read and initial.
I specifically authorize the release of data and information relating to: (initial all that apply)
___ 1. Substance abuse (alcohol/drug)
___ 2. Mental Health (includes psychological testing, ADHD related information).
___ 3. HIV related information (AIDS relating testing)

The 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 the Des Moines Pediatric and Adolescent Center Medical Records Department.

Signature of Parent or Legal Representative _____ Date _____

Prohibition on 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 records or by state law for mental health records, federal requirements (42 C.F.R. PART 2) and state requirements (Iowa Code Ch. 2288) prohibit further disclosure without 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 disclosures of alcohol/drug abuse or mental health information.