All Ages Pediatrics P.C.

1207 N. Jefferson St. Suite 1, Ottumwa, IA 52501 Phone 641-682-5437 Fax 641-682-1628

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Legal Name:____ Birth Date:_____________________

By signing this form, I am allowing All Ages Pediatrics P.C. to release and/or obtain medical information concerning the above named patient to/by the person or facility listed below.

This information may be share by: Viewing____ Verbal____ Copies____ CD____ Fax____ (Please note burning to a CD is only possible when transferring electronic information.)

____

Name of Person and/or Institution who will release/receive information

____

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (what clinics or what dates if known):_______________________________

Medication list ______________________________ Laboratory results______________________________

Allergy list ______________________________ X-ray and imaging reports,______________________

Immunization record ______________________________ Consultation reports______________________________

Problem List (Pt. Summary) ______________________________ Test results (e.g. EKG, PFT, etc.)______________________

History and Physical ______________________________ Billing Information ______________________________

Discharge summary______________________________ Other______________________________

Please check the reason for release below, and provide date by which the info is needed:______________________

Insurance____ 2nd opinion____ Rehab/disability____ Personal File____ Moving out of area____

Legal____ Transferring care____ PCP/Medical Home____ Mutual Patient____

I specifically deny the release(initial any category NOT to be released) ____Substance Abuse ____Mental Health ____HIV-related info ____Genetic tests/info

This authorization is effective for______ or no longer than 1 year from the date on which it is 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 Chief Compliance Officer at *All Ages Pediatrics P.C.* A photocopy or facsimile of this release shall have the same effect as an original. I understand I have the right to inspect the information to be disclosed, and include my written statement about the record, upon proper notification to and under appropriate conditions established by *All Ages Pediatrics P.C.* I acknowledge that the information to be released my include material that is protected by State and Federal Law (42 CFR Part for Alcohol/Drug abuse, and State Law (Iowa Code ch. 225 and 141) for Mental Health, and HIV/AIDS treatment,) applicable to either mental health, and/or drug and/or alcohol abuse and/or HIV/AIDS, and my signature authorizes release of such information, unless exceptions have been stated above. _______ Initials and does not permit redisclosure without specific consent.

I understand that, while completion of the authorization to release information is not required for evaluation or treatment, if the evaluation or treatment is for the purpose of creating a medical report to a third party, and there is no consent to release information to that party, then this may result in cancellation of said service.

______________________________ ______________________ ______________

Signature of Patient or Legal Guardian Printed Name Date

______________________________ ______________________________

Complete Mailing Address/Street/P.O. Box City/State Zip Code

______________________________ ______________________________

Relationship, if Not the Patient Witness Signature