Pediatric Associates of University of Iowa Stead Family Children's Hospital

Monday – Thursday 7:00 am – 8:00 pm Friday 7:00 am – 5:00 pm Saturday 8:00 am – 12:00 pm Sunday 12:00 pm – 4:00 pm

Medical Record Release and Transfer Out of Practice Information

To be completed by the Patient/Guardians: **Today's Date:** _____

Patient's Name: _____ Date of Birth: _____

_____ _____

_____ _____

_____ _____

I hereby authorize Pediatric Associates of University of Iowa Stead Family Children's Hospital, LLC to disclose the following information to the below listed party:

☐ Complete Medical History ☐ Mental Health* ☐ Substance Abuse * ☐ HIV Testing/Results*

Name of Person, Physician or Health Care Facility to Receive Records: ***(list one entity only)***

Name: _____

Address: _____

Reason for Medical Records Release:

☐ Transferring Medical Care to another Physician
☐ Going to Specialist/Second Opinion but will remain active patient at Pediatric Associates
☐ For Personal Use
☐ Coordinating Treatment
☐ Other _____

If you are moving, please complete the following:

New Address: _____

City: _____ State: _____ Zip: _____

I understand that I may revoke this authorization by providing written revocation to Pediatric Associates of University of Iowa Stead Family Children's Hospital, LLC. I understand that I may review the disclosed information. I also understand that any information which has been released prior to the revocation may be used for purposes listed above. Unless revoked, this authorization to release information will expire in 60 days from date signed. Furthermore I understand that if I am transferring to another medical provider, and therefore terminating my patient relationship with Pediatric Associates of University of Iowa Stead Family Children's Hospital, LLC, that I am financially responsible for the balance listed above and any further charges incurred on my account. I understand that the first release of records for transferring medical care or for personal use is free and subsequent requests are $20.00.

Patient (over 18)/Gaurdian Signature: _____ Date: _____

***SPECIFIC AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, SUBSTANCE ABUSE or HIV INFORMATION:**
I acknowledge that any data to be released, that is protected by federal law and is applicable to mental health, substance abuse or HIV-related care requires the patient's signature to be released.

Patient (over 18)/Gaurdian Signature: _____ Date: _____

Person picking up Medical Records: _____
Print Signature Date

For Office Use Only:

Account #_____ Current Balance_____ Total Account Balance_____

☐ Medical Records Copied and Sent Initials: _____ Date: _____

☐ Business Office Review of Account Done Initials: _____ Date: _____

Comments: _____