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

Name of Physician Office, Medical Clinic or Hospital releasing information to Pediatric Associates of University of Iowa Stead Family Children's Hospital, LLC:

Name: ____ Date: ______________

Address: ____ Phone: _____________

To Whom It May Concern:

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

☐ Complete Medical History   ☐ Mental Health*   ☐Substance Abuse *

☐ HIV Testing/Results*

I am making this request for the following patients:

Patient's Name: ______________________________ Date of Birth: ___________________

______________________________ ___________________

______________________________ ___________________

______________________________ ___________________

Please mail the requested information at your earliest convenience to:

☐ Pediatric Associates – Iowa City Clinic
1360 North Dodge St Ste 1500
Iowa City, IA 52245
Fax: (319) 351-9367

☐ Pediatric Associates – Coralville Clinic
2593 Holiday Road
Coralville, IA 52241
Fax: (319) 688-2930

I understand that I may revoke this authorization by providing written revocation to the above listed entity. 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.

Signed: ____ 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 Signature: ______________________________________ Date: _______________