Pediatric & Young Adult Clinic
1417 A Avenue East, Suite 100
Oskaloosa, IA 52577
Phone: 641-673-7537 Fax: 1-877-904-9730

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 in effect 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 Pediatric & Young Adult Clinic. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the organization.
- This form does not authorize redisclosure of medical information beyond the limits of this consent.

PATIENT IDENTIFICATION	Full Legal Name:__________ Date of Birth:__________ Last 4 Digits of SSN:__________ Address:__________ Phone:__________ __________
PROVIDER (Who is to disclose the information?)	Name:__________ Address:__________ City, State, Zip:__________ Telephone:__________ Fax:__________
RECIPIENT (Who is to receive the information?)	Name: Pediatric & Young Adult Clinic Address: 1417 A Avenue East, Suite 100 City, State, Zip: Oskaloosa, IA 52577 Telephone: 641-673-7537 Fax: 1-877-904-9730
PURPOSE OF RELEASE	☐ To update primary care provider, Discussion/Coordination of Care ☐ Transferring care ☐ Second Opinion ☐ Other (please specify)__________
INFORMATION TO BE RELEASED	☐ Complete Records ☐ Laboratory/Radiology Reports ☐ Immunization Records ☐ Records from other clinics (please specify)__________ ☐ Other (please specify)__________

*I understand that my healthcare and payment for my healthcare will not be affected by this authorization.

I understand that the information may be released electronically, and 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 Information_____ Genetic Testing_____

Signature of patient or legal representative__________
Relationship to patient__________ Date__________
Witness__________ Date__________