Pediatric And Adult Allergy, P.C.

The Asthma Care Center

Robert Colman, M.D.
Whitney Molis, M.D.
Tara Federly, M.D.

1212 Pleasant St – Suite 110
Des Moines, IA 50309-1490
(515) 244-7229

Authorization to Release Medical Records

I hereby authorize: _____

to release medical records and data pertaining to:

Patient Name:	**Street Address:**
Date of Birth:	**City, State, Zip Code:**
Social Security Number:	**Phone Number:**

Please specify which records should be released:

Records pertaining to _____

_____

Between the dates of _____ and _____

Please specify the purpose for the release:

❑ Transfer to another doctor ❑ Moving ❑ Personal records

❑ Transfer (insurance change) ❑ Legal ❑ Other:

Please specify the desired method for the release:

❑ Pick-up

❑ Fax (please complete the information below; we may need to mail the records instead of faxing them)

❑ Mail

Patient or Business / Office: Pediatric & Adult Allergy	**Street Address:** 1212 Pleasant St – Suite 110
Attention:	**City, State, Zip Code:** Des Moines, IA 50309
Fax Number: (515) 244-7233	**Phone Number:** (515) 244-7229

PLEASE ALSO COMPLETE THE REVERSE SIDE. THANK YOU!

Office use only:

Completed by: _____

Date records picked-up / faxed / mailed: _____

REDISCLOSURE

Iowa and/or federal law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, as indicated below.

Please circle your choice and cross out the option you do not want:

I SPECIFICALLY AUTHORIZE AND CONSENT TO REDISCLOSURE

I SPECIFICALLY DO NOT AUTHORIZE AND CONSENT TO REDISCLOSURE

Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:

> This information has been disclosed to you from records protected by State law and/or Federal confidentiality rules (42 CFR Part 2). The State law and/or Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by State law and/or 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
>
> See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to:

Please circle your choice and cross out the option you do not want:

YES	NO	Substance Abuse (Drug or Alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.
YES	NO	Mental Health Information from all health care providers and facilities and any other person or entity in possession of records concerning me.
YES	NO	AIDS-related information, Diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

In order for the above information to be released, you must sign here and at the end of this form.

Signature of Patient/Guardian: _____ Date: _____

Relationship, if not the patient: _____

REVOCATION

I understand that I have the right to revoke (take back) my authorization at any time by submitting a written and signed request to Pediatric & Adult Allergy, P.C. I also understand that Pediatric & Adult Allergy, P.C. may have already acted on this release.

AUTHORIZATION

- A photocopy , or exact reproduction of this signed authorization shall have the same force and effect as this original.
- I hereby authorize the release of information as indicated above.

Expiration Date for Authorization: _____

Patient's Name (please print): _____

Signature of Patient/Parent/Guardian: _____ Date: _____

Relationship, if not the patient: _____