All Ages Pediatrics P.C.
301 W 2nd St
Ottumwa, IA 52501

Phone: (641) 682-5437
Fax: (641) 682-1628

Email: Allagespediatrics1@gmail.com
Website: www.allagespediatrics.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Legal Name: _____ **Patient's Date of Birth**: ___/____/_____

Records **FROM**	Records **TO**
Facility Name: _____	Facility Name: _____
Facility Address: _____	Facility Address: _____
Facility Phone Number: _____	Facility Phone Number: _____

I am authorizing the release of records from☐ Birth☐These Dates _____ and **because**

☐2nd opinion ☐Insurance ☐Legal ☐Transferring Care ☐Mutual Patient

☐Personal records(☐Paper☐USB☐CD☐Email) ☐Other_____

I ACCEPT the following records to be released: ☐All Records or see below

- ☐ Allergy List
- ☐ Discharge Notes/Summaries
- ☐ Emergency Notes/Summaries
- ☐ History and Physicals
- ☐ Immunization Records
- ☐ Laboratory Results
- ☐ Office visits (sick and well)
- ☐ Operative/Procedure
- ☐ Pathology Results
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Operative/Procedure Notes
- ☐ Test Results (EKG,PFT, etc.

I specifically DENY the release of the following

☐Genetic Tests/info ☐HIV related info ☐Mental Health ☐Substance abuse

Parent/Guardian Print Name: _____ Parent/Guardian Signature: _____

Parent/Guardian Full Address: _____

Relationship to Patient: _____ Signature Date: _____ Time: _____

This Authorization is effective for 3 years from the date signed or until _____ (shorter time period.) Initials_____
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, electronic version 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 may include material that is protected by State and Federal Law. Further, I understand that recipients of this information may possibly re-release the information without proper authorization, and 2.) once information is disclosed, it may no longer be protected by federal privacy regulation. 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. I understand that the receiving facility will send records within 30 days of receipt, not the signature date, or attempt to notify me of an extension.