

**Pediatric Associates of Iowa City and Coralville
Medical Record Request**

Physician Office, Medical Clinic or Hospital to Release Records:

Name: _____

Address: _____

Date: _____

To Whom It May Concern:

I hereby authorize you to disclose the following information to Pediatric Associates of Iowa City and Coralville:

- 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:

- | | |
|---|---|
| <input type="checkbox"/> Pediatric Associates- Iowa City Clinic
605 E. Jefferson St.
Iowa City, IA 52245
FAX: (319) 351-9367 | <input type="checkbox"/> Pediatric Associates- Coralville Clinic
2591 Holiday Rd.
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 release prior to the revocation may be used for purpose 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's Signature: _____ Date: _____

.....