

Pediatric Associates of Iowa City and Coralville
Medical Record Request and Transfer Information

Account Number: _____ Date: _____

Current Patient Due Balance: _____ Total Account Balance: _____

To be completed by the Patient/Guardian:

Patient's Name _____ Date of Birth: _____

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

- Complete Medical History Mental Health* Substance Abuse* HIV Testing/Results*

Person, Physician or Health Care Facility to Receive Records: *(list one entity only)*

Name: _____

Address: _____

Reason for Medical Records Request:

- Transferring Medical Care to another Physician For Personal Use
 Going to a Specialist/Second Opinion Appointment, but will remain an active patient at Pediatric Associates
 Other (please list) _____

If you are moving, please complete the following:

New Address: _____

City: _____ State: _____ Zip: _____

New Telephone: _____ Date of Move: _____

I understand that I may revoke this authorization by providing written revocation to Pediatric Associates. 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. Furthermore I understand that if I am transferring to another medical provider, and therefore terminating my patient relationship with Pediatric Associates, that I am financially responsible for the balance listed above and any further charges incurred on my account. I understand that the first release of records for transferring medical care or for personal use is free and subsequent requests are \$20.00.

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: _____

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For Office Use Only: Medical Records copied and Sent Initials: _____ Date: _____

Business Office Review of Account Done Initials: _____ Date: _____ Final Bill Sent Initials: _____ Date: _____

Comments: