CONSENT TO RELEASE OF INFORMATION

Quad Cities Pediatrics, P.C.
5510 Utica Ridge Rd, Suite 100
Davenport, IA 52807

Please PRINT (except signature) and provide complete information in each section.

Patient Name _____

Birth Date _____ Soc. Sec. # _____

I understand by signing this form, I am allowing Quad Cities Pediatrics, P.C. to release medical information concerning the above named patient to:

_____
Name of Person and/or Institution

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates where indicated): ____Minimum necessary or specify:

__ ALL MEDICAL RECORDS

__ Medication list __ Allergy list __ Immunization record ____ Problem List (Pt. Summary list)
__ Most recent history and physical or specific date_____
__ Most recent discharge summary or specific date_____
__ Laboratory results, specify type ordate_____
__ X-ray and imaging reports, specify type or date_____
__ Consultation reports (specify doctor or clinic) _____
__ Test results (i.e. EKG, PFT, etc.), specify type and date_____
__ Billing Information, specify_____
__ Other, specify_____

As per my request, the reason for release of information is: ___ moving out of area ___ transferring care ___ 2nd opinion ___ other medical care ___ personal file ___ legal ___ insurance ___ other (specify) _____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to the Office Manager, Quad Cities Pediatrics, P.C., 5510 Utica Ridge Rd, Suite 100, Davenport, IA, 52807. I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Director of Health Information Management at the above address. I understand that Quad Cities Pediatrics, P.C. may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that the information to be released 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 _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____.

_____ _____
Signature of Patient or Legal Guardian Date

_____

_____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, if Not the Patient Witness Signature