

CONSENT TO OBTAIN INFORMATION

**University of Iowa Hospitals and Clinics (UIHC)
Child Health Specialty Clinics (CHSC)**

Please PRINT (except signatures) and provide complete answers/addresses in each section.

Patient Name: _____

Birth Date: _____

I understand that by signing this form I am allowing CHSC and/or the University of Iowa Hospitals and Clinics (UIHC) to obtain information concerning the above patient from:

Person / Institution Name Address City, State, Zip
--

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

<input type="checkbox"/> Most recent discharge summary/evaluation report _____	<input type="checkbox"/> Most recent history and physical date _____	<input type="checkbox"/> Test results date _____
<input type="checkbox"/> Most recent education evaluation/report or specific date _____	<input type="checkbox"/> Consultation reports specific date _____	<input type="checkbox"/> Other (specify) anything pertaining to emotional or behavioral issues. <input type="checkbox"/> Parent/Legal Guardian consents to the use of e-mail for communicating patient information to the specific agency/provider listed.

The reason for obtaining information is: transferring care other medical care personal file
 other (specify) _____

This authorization is voluntary and I may cancel this consent to obtain information at any time by sending written notice to Child Health Specialty Clinics 100 Hawkins Drive Iowa City, IA 52242. 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 redisclosure 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 Child Health Specialty Clinics at the above address.

I understand that CHSC/UIHC 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

UIHC use only: Upon satisfying this release, date & sign, record on the Release of Information Tracking (ROIT) system and scan the form in to Epic. **If unable to satisfy this release or if unable to enter/scan this information on the ROIT system, forward to the Release of Information Office, Health Information Management (HIM) Department, 2 SRF, for processing.**

Info. sent: _____ Recorded on ROIT System: _____
Name/Dept. Date Name/Dept. Date