Hosp #________________

CONSENT TO RELEASE 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 release information concerning the above patient to:

Person / Institution Name
Address
City, State, Zip

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

☐ Most recent discharge summary/evaluation report ________	☐ Most recent history and physical date ________________________	☐ Test results date ________________________
☐ Most recent education evaluation/report or specific date __________	☐ Consultation reports specific date __________________	☐ Other (specify) anything pertaining to emotional or behavioral issues. ☐ Parent/Legal Guardian consents to the use of e-mail for communicating patient information to the specific agency/provider listed.

The reason for disclosing 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 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 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

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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