CONSENT TO RELEASE INFORMATION

Patient Name: ________________________________ Date of Birth: ____________________

I, the undersigned, herby authorize **Perinatal Center of Iowa** to disclose and/or deliver to:

____
Name of Physician/Office to send records to

____
Street Address City, State Zip

____
Phone Fax

A copy of the clinical notes pertaining to my evaluation and treatment and copies of the following information as indicated (if additional information is necessary):

O History
O Physical
O Problem List
O Medication List
O X-ray Reports
O Laboratory Reports
O Surgical Reports
O Other Information as indicated

____

Please specify reason for release of information, i.e., continuing medical care, second opinion, etc.

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SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: (check the appropriate box)

- Substance Abuse (Alcohol/Drug Abuse) O
- Mental Health (Includes Psychological testing) O
- HIV-Related Information (Includes Testing) O

______________________________________ ______________________
Signature of Patient or Legal Guardian Date