

CONSENT TO RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____

I, the undersigned, hereby authorize _____, to disclose and/or deliver to:
(Name of Referring Physician)

**Perinatal Center of Iowa
330 Laurel Street, Suite 2300
Des Moines, IA 50314
Phone (515) 643-6888
Fax (515) 643-6899**

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):

- | | |
|---------------------------------------|--|
| <input type="radio"/> History | <input type="radio"/> X-ray Reports |
| <input type="radio"/> Physical | <input type="radio"/> Laboratory Reports |
| <input type="radio"/> Problem List | <input type="radio"/> Surgical Reports |
| <input type="radio"/> Medication List | <input type="radio"/> Other Information as indicated |

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

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)
- Mental Health (Includes Psychological testing)
- HIV-Related Information (Includes Testing)

Signature of Patient or Legal Guardian

Date