

Pediatric Cardiology, P.C.
 330 Laurel Street, Suite 2200
 Des Moines, IA 50314
 515-288-1097
 Fax: 515-288-2847

Authorization to Release Protected Health Information

Name: (First, Middle, Last)	Birth Date:
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Instructions: If any section is incomplete, this form may be invalid and the request cannot be processed.

Release Information From	Release Information To
<input type="checkbox"/> Pediatric Cardiology, P.C. 330 Laurel St., Ste. 2200 Des Moines, IA 50314	<input type="checkbox"/> Pediatric Cardiology, P.C. 330 Laurel St., Ste. 2200 Des Moines, IA 50314
<input type="checkbox"/> Other Facility & Address, including fax, if known	<input type="checkbox"/> Other Facility & Address, including fax, if known
Name:	Name:
Address:	Address:
City:	City:

Purpose of Release

<input type="checkbox"/> Treatment/Continued Care	<input type="checkbox"/> Personal	<input type="checkbox"/> Legal Purposes
<input type="checkbox"/> Application for Insurance	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Payment of Insurance
<input type="checkbox"/> Other		

Information to be Released

Service Dates (approximate)	Information Needed By (specific date)
<input type="checkbox"/> Clinic Letter <input type="checkbox"/> EKG <input type="checkbox"/> Echo Report <input type="checkbox"/> Billing Statements <input type="checkbox"/> Cath Report <input type="checkbox"/> Operative Report	<input type="checkbox"/> Other

I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS and genetics.

This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. I may be charged for copies in accordance with state law. The provider/facility will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the law.

This authorization will expire one year from the date signed unless I indicate an earlier date or event here _____

ATTENTION: This is a legal document/ Please read carefully. By signing, you agree that you understand and accept the terms.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and incapable of signing**, a legally authorized substitute may sign and date the form.
 - Legal Guardian or Conservator Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form.
 - Parent Legal Guardian

Signature	Date Signed
Printed Name of Person Signing (If not patient)	
Address	
City, State, Zip	Phone