Blank Children's Hospital
UnityPoint Health

Blank Children's Pediatric Clinics
1212 Pleasant Street, Ste. 300
Des Moines, Iowa 50309
Phone: (515) 241^8923 Fax: (515)241^6497

Authorization for Release of Medical Information

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the entity authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Children's Hospital Physicians. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions by Children's Hospital Physicians.

Patient Identification	Name (Last, First, middle initial): ____ Date of Birth: ____ Any previous names under which records may be kept: ____ Telephone number where we can reach you if we have questions: (_____)____
Healthcare Provider **(Who is releasing the information?)**	Name: Dr. Arenas Morales, Blank Nephrology Street Address: 1212 Pleasant St., Suite 410 City, State, Zip: Des Moines, IA, 50309 Telephone number: (515) 241 6431____Fax number: (515) 241-5127
Recipient **(Who is to receive the information?)**	Name: University of Iowa Pediatric Nephrology Street Address: 8605 Chambery Blvd. City, State, Zip: Johnston, Iowa 50131 Telephone number: (1) 1-800-777-8442 _Fax number: (319) 384-9616
Purpose of the Release **(Check all that apply)**	At request of the patient (or legal representative) Discussion/coordination of care with family members involved with patient's care **X Transferring medical care to another health care provider** For claims processing purposes (e.g., third-party liability claims) Other (please specify): ____
Information **(What information should be released?)** **(Check all that apply)**	# Records dating from:____to ____ **X Only records created by this office** # All affiliated clinics using the UnityPoint Health electronic health record # Other (please list specific records): ____

I understand that the information to be released will not include information in the following categories, unless I specifically authorize the release. I authorize release for:

___Substance Abuse_____Mental Health____HIV-Related Info ____

Signature **Date**

I understand my healthcare and payment for my healthcare will not be affected by this authorization.

Signature of patient or legal representative:____Date:____

Relationship to patient, if signed by legal representative: ____

PROHIBITION OF REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse treatment records or by state law for mental health records, federal requirements (42 CFR Part 2) and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse treatment or mental health information.