VIRTUE MEDICINE

221 E. College St. Ste 212
Iowa City, Iowa 52240
Phone: 319-338-5190
Fax: 319-354-3718
www.virtuemedicine.com

Request for Release of Confidential Information

Client: ____, Date of Birth __________________________,

Address: ____

The entity below is authorized to release information from their records:

Entity/Address:____

____

Phone: _____________________________________ FAX: ____

❑ For further medical evaluation, treatment, or care ❑ For Consultative-Coaching in Professionalism
❑ Other: ____

The information to be disclosed is marked below, concerning the time between _________ and _________.

❑ Hospital admission and discharge summaries ❑ Medical or Mental Health Evaluations
❑ Labs, Radiology ________________________ ❑ Medical progress notes and treatment plans
❑ Performance Reviews, Complaints, Interventions ❑ Job Description, Employment Records
❑ Other: ____
Details:____

❑ Please forward copies of the requested records to: ____ at Virtue Medicine P.C., 221 East College St. Ste 212, Iowa City, IA 52240. Phone: 319-338-5190. Fax: 319-354-3718
❑ Please release information in following conditions: ____
____

If medical coordination of care, HIV-related and drug/alcohol information in the medical records are authorized for release unless indicated here: ❑ Do not release HIV information ❑ Do not release drug/alcohol information

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. I release the source of the records from any and all liability incurred through release of my records. This request is entirely voluntary on my part. I understand that I may revoke this consent at any time except to the extent that action based on this consent has already been taken.

This consent will expire automatically **in 2 years**, or ❑ _______________________ from the date on which it is signed, unless revoked in writing. I agree that a photocopy of this form is valid, if signed by client or legal guardian.

_________________________________ _______________________________ _______________

Signature of client Printed name Date