

# 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