Waggoner Pediatrics of Central Iowa

Putting families first for over 25 years.

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18+ Year Consent

Patient Name_____ Date of Request_____

Date of Birth_____ Patient Account #_____ Daytime Phone #_____

Address_____ City_____ State_____ Zip_____

I hereby authorize Waggoner Pediatrics of Central Iowa, either orally or in writing to release information to:

_____ Daytime Phone #_____
Name & Relationship to Patient

_____ Daytime Phone #_____
Name & Relationship to Patient

_____ Daytime Phone #_____
Name & Relationship to Patient

_____ Daytime Phone #_____
Name & Relationship to Patient

Any and/or all personal health information with the exception of the following:

_____

_____

Specific authorization for release of information protected by State or Federal law

(Please read and initial)
I specifically authorize the release of data and information relating to (check all that apply):

_____1. Substance abuse (alcohol/drug)

_____2. Mental Health (including psychological testing, ADHD related information)

_____3. HIV related information (AIDS related testing)

Signature of Patient_____ Date_____

1. I understand that this authorization will expire three years from my last date of service.
2. I understand that I may revoke this authorization at anytime by notifying Waggoner Pediatrics of Central Iowa in writing.

By signing below, I acknowledge that I have read and understand this authorization.

_____ _____
Signature of Patient Date