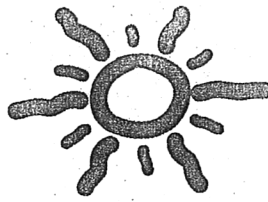


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Pediatric Center P.C.
"Our focus is your child"

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MD

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CONSENT TO OBTAIN INFORMATION

PATIENT NAME: _____

Address: _____ City: _____ St _____ Zip _____

Phone: _____ Date of Birth: _____

I, the undersigned, hereby authorize Pediatric Center, P. C. to obtain from:

(name of person or institution) _____

(street) _____ (city) _____ (state) _____ (zip) _____

a copy of the clinical notes pertaining to my evaluation and treatment and copies of the following information as indicated (if additional information is necessary):

History Progress Notes Physical Exam (list date) _____
 Lab Reports Problem/Medication List Immunization Record X-ray Reports

I understand the information is being released for the following reason(s):

continuing medical care second opinion transfer of medical care patient moving
 personal file referral other (specify) _____

I give special permission to release any information regarding:

(please initial on lines below to specifically authorize release of this information)

_____ Substance Abuse (alcohol/drug abuse)
_____ Psychiatric/Mental Health Information
_____ HIV Related Information (AIDS related testing)
_____ Child Abuse/Adoption

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signature of Patient/Legal Guardian: _____

Relationship to patient: _____ Witness: _____ Date _____